

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-10-68. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15040

15050

1. DECEASED-NAME (Type or Print) Leroy Frye Adams			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 10 8 1968			2b. HOUR 9:45 M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6/24/27	6. AGE (In years lost birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 10 8 1968		
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Casual Labor		12b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 30 Roessner Ave.
14. FATHER'S NAME First Middle Last David Robert Adams			15. MOTHER'S MAIDEN NAME First Middle Last Mazie Sedalia Stover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 212-24-3652		17. INFORMANT David R. Adams ADDRESS 30 Roessner Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arsenic Poisoning DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9507								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/4 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 9716								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Edward W. Ditto, III				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10-10-68		
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md.		
24. FUNERAL DIRECTOR W. G. Horst ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

635

17/10/1941 10/11/1941 10/11/1941

150

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1997

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15. 11. 1951

1967-1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15041

15051

1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Nina Marie Beeler						Month Day Year October 19, 1968			1:50P M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		Dec. 31, 1884			83		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Boonsboro, Md.			U. S. A.						Washington			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Clearview Nursing Home			Housewife			Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Washington			Boonsboro			X			12 Saint Paul St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Michael Bender			Mary E. Brownley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No.			218-50-4311			Mr. James M. Beeler, Boonsboro, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Right Pneumonia</u>										3 weeks				
4339 DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>cardiac thrombosis</u>										3 weeks				
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>Generalized arteriosclerosis</u>										Year				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
332 X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17-</u> , 19 <u>57</u> , to <u>Oct 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Joseph Secondary</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>10-21-68</u>								
22d. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>			22e. ADDRESS <u>Boonsboro Md 21713</u>											
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Burial</u>			23b. DATE <u>10-22-68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Boonsboro, Wash. Co., Md.</u>					
24. FUNERAL DIRECTOR <u>John H. Bast, Jr.</u>			ADDRESS <u>112 N. Main St. Boonsboro, Md</u>			25a. REC'D BY REGISTRAR <u>OCT 24 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1998

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Mr. James H. Smith, "American Express"

0013-788X/96/0005-0000\$05.00/0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-70
30M REV 10-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
15042					15052					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
Joshua Paul Biser					October 2, 1968			2:40 A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Dec. 25, 1899			68		10 8	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Mt. Carmel, Md.		U. S. A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington County Hospital			Farmer			Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Edwin Biser			Carrie Flook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.			215-36-6909		Miss Thelma M. Biser, Rfd. 2, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and aneuria									8 hrs.	
4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Arteriosclerotic heart disease									2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
Diabetes mellitus (3 yrs.)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) this hospital attended the deceased from 1/28, 1965, to 10/2, 1968, that (I) was lost saw the deceased alive on 10/2, 1968, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
		10/2/68								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Donald E. Martin, M.D.		363 S. Cleveland Avenue, Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-4-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		OCT 4 1968								

15052

15052

October 2, 1968 2:40 A. M. Alan Paul Thomas

68 Dec. 25, 1969 10 4

Washington, D. C. U. S. A.

Washington County Hospital Farmer Farming

Washington County Hospital 10. 2

Edwin Alan Carrie Block

61-55-009 Washington, D. C. 2, Washington, D. C.

10-1-68 Washington Cemetery Washington, D. C.

John S. Paul, Jr. 112 W. Main St. Washington, D. C. 1968

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15043

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15053

1. DECEASED-NAME (Type or print) John Allen Boward			2a. DATE OF DEATH Month October Day 25 Year 1968			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH December 31, 1914		6. AGE (In years lost birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Coal, Bldg. Sup.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 40 Alexander St.		14. FATHER'S NAME First Middle Last Lloyd Ellsworth Boward		15. MOTHER'S MAIDEN NAME First Middle Last Elsie May Fogle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 217-09-9794		17. INFORMANT Address Mrs. Iona A. Boward 40 Alexander St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia 4120 DUE TO, OR AS A CONSEQUENCE OF (b) hypertensive cardiovascular disease and benign DUE TO, OR AS A CONSEQUENCE OF (c) nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 - 4 days 10-15 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (his hospital) attended the deceased from Sept 21, 1968 , to Oct 25, 1968 , that (I) (we) last saw the deceased alive on Oct 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward W. Ditto, III				22c. DATE SIGNED 10-26-68			
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.				22e. ADDRESS 217 W. Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/28/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington Md.	
24. FUNERAL DIRECTOR Rest Haven Funeral Chapel Hagerstown, Md.				25a. REC'D BY REGISTRAR OCT 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

232

3.5011

• **RESEARCH DESIGN**

292

[illegible][illegible]

Wm. D. Webb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Woodrow		Middle W.		Last Bowers		2a. DATE OF DEATH Month Oct. Day 24 Year 1968		2b. HOUR 8:15 P			
3. SEX Male			4. RACE White			5. DATE OF BIRTH 7/15/11			6. AGE (In years lost birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON			Md.		
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) maintenance (laundry) hospital			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 197 1/2 E. Main St.			
14. FATHER'S NAME First William			Middle H.			Last Bowers			15. MOTHER'S MAIDEN NAME First Gertrude			Middle Holbrook		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 211-03-5545			17. INFORMANT Mrs. Lena Vogt Bowers			17a. ADDRESS 197 1/2 E. Main St. Westminster, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus 150X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 Mos.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 150X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) the hospital attended the deceased from Aug. 6 , 1968, to Oct. 24 , 1968, that (I) we last saw the deceased alive on Oct. 24 , 1968, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) and (did) not view the body after death.														
22b. SIGNATURE Edwin G. Riley, M.D.						22c. DATE SIGNED 10/25/68								
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley, M.D.						22e. ADDRESS Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/28/68			23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster Md.			23d. LOCATION (City or Town) (County) (State) Westminster Md.					
24. FUNERAL DIRECTOR J. J. Myers, Jr. Westminster, Md.						25a. REC'D BY REGISTRAR DATE OCT 28 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15045

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15055

1. DECEASED-NAME (Type or Print) Harry Allen Breeden			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 10 19 1968			2b. HOUR 4a M				
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 12 1899	6. AGE (in years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS 4 DAYS 6	IF UNDER 24 HRS HOURS 6 MIN.	2c. DATE PRONOUNCED DEAD Month 10 Day 19 Year 1968			2d. HOUR 7:05 PM	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Sharpsburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 118 W. Chaplin St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farm Labor			12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 118 W. Chaplin St.			
14. FATHER'S NAME First Ashby Middle Breeden Last Breeden			15. MOTHER'S MAIDEN NAME First Bessie Middle Jones Last Jones			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16b. SOCIAL SECURITY NO. 2325 26-5433
17. INFORMANT Mrs. Josephine Frye			ADDRESS Shepherdstown W. Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary artery disease Years DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Howard N. Weeks			M.D. Howard N. Weeks			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/19/68		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Washington County				
23a. BURIAL, CREMATION, REBURY (Specify) Burial		23b. DATE Oct. 21-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.				
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.				ADDRESS		25a. REC'D BY REGISTRAR OCT 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

Subject

Alias

Race

Date

White Male

Place of Birth

U.S.A.

Age

Date of Birth

Date of Birth

Date of Birth

Date of Birth

Date of Birth

Date of Birth

Name

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 110
30M REV 11/68

15046										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15056																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										a																																							
ALBERT FRANK BROWN, SR.										OCTOBER 6 68										5:05 PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
MALE										WHITE										MARCH 11, 1906										62 YRS.										MONTHS DAYS HOURS MIN																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
PENNSYLVANIA										U.S.A.																				WASHINGTON																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
HAGERSTOWN										WASHINGTON COUNTY HOSP.										TUBE MILL OPERATOR										CEMENT PLANT																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										WASHINGTON										HAGERSTOWN										YES										337 BROOKLINE AVENUE																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																													
ALBERT BROWN										THERESA SOMODITZ																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										213-10-6922										MRS HELEN BROWN										337 BROOKLINE AVE.,																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										Cardiac decompensation										3 wk																																							
4129										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Arteriosclerotic heart disease										wk																																							
4200										DUE TO, OR AS A CONSEQUENCE OF																																																	
(c) Generalized arteriosclerosis																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Bacterial pneumonia; progressive central nervous system																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (the hospital) attended the deceased from Jan 6, 1968, to Oct 6, 1968, that (I) (we) lost saw the deceased alive on Oct 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Lawrence L Packer, Jr.										10/7/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
LAWRENCE L PACKER, JR., M.D.										145 W WASHINGTON ST., HAGERSTOWN, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										10/8/68										REST HAVEN CEMETERY										HAGERSTOWN, WASHINGTON, MD.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
Charles M. Rauer										HAGERSTOWN, MARYLAND										DATE OCT 9 1968										Charles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
George Henry Buys						Month Day Year October 13, 1968			10:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		Nov. 20, 1906			61 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.A.				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown,			Washington Co. Hospital			Salesman			Music Store
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown		YES		1039 Hamilton Blvd.
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Dr. Peter Buys				Lena DeGroot					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			W.W.2 220-09-7656		1039 Hamilton Blvd. Mrs Dorothy Buys Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Brain Tumors</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension of Kidney</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo. 6 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>180X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8-2-68		Brain Tumor							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>68</u> , to <u>Oct. 13</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct. 13</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22b. SIGNATURE <u>Lloyd A. Hoffman</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 10-14-68	
22d. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>								22e. ADDRESS 214 N. Potomac St.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 16/68		Rest Haven Cemetery		Hagerstown, Maryland.			
24. FUNERAL DIRECTOR Hagerstown, Md. ADDRESS Andrew K. Coffman Funeral Home Inc.						25a. REC'D BY REGISTRAR DATE OCT 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15057

15057

FEDERAL BUREAU OF INVESTIGATION

AM

October 13, 1958 10:45

George Henry Guy

Nov. 20, 1906

White

Male

Washington

U.S.A.

New York

Hagerstown,

Washington Co. Hospital Callesman

Basic Steps

1039 Hamilton Blvd.

Washington Hagerstown

Maryland

Lena Degroot

Dr. Peter Guy

1039 Hamilton Blvd.

220-09-1656 Mrs. Dorothy Guy Hagerstown, Md.

Yes

W.W.C.

Hagerstown, Maryland

Burial Oct. 10, 1958 East Haven Cemetery

Hagerstown, Md.

Andrew K. Collins Funeral Home Inc.

Oct 12 1958

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15048

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15058

1. DECEASED-NAME (Type or Print) First Middle Last Lloyd Maxwell Cale			2a. DATE KNOWN OF DEATH Month Day Year 10 9 1968			2b. HOUR 2:12 M		
3. SEX male	4. RACE white	5. DATE OF BIRTH 6-10-1907	6. AGE (in years last birthday) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 10 9 1968			2d. HOUR 7:12 M
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 67 & 40			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY General	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 416 E. Mitchell, Ave.			14. FATHER'S NAME First Middle Last Virgil M. Cale					
15. MOTHER'S MAIDEN NAME First Middle Last Rosie Fitzgerald			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					
16b. SOCIAL SECURITY NO. WW 11			17. INFORMANT ADDRESS Mr. Virgil Cale Covington, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury to chest with rupture heart - Lt. hemothorax DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Fractures DUE TO, OR AS A CONSEQUENCE OF (c) 816.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Turned
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 8234								
19a. DATE OF OPERATION 10-9-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Lost control of Auto - Struck Embankment			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 10-9-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Lost control of Auto - Struck Embankment				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. City or Town County State Rt 67 & 40 Boonsboro Wash Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 10-10-68		
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			217 W. Washington St. Hagerstown, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-14-68			23c. NAME OF CEMETERY OR CREMATORY Gettysburg National Cem.		
23d. LOCATION (City or Town) (County) (State) Gettysburg, Pa.			24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md.			25a. REC'D BY REGISTRAR OCT 14 1968		
25b. REGISTRAR'S SIGNATURE J. Charles Judge								

100-443887-100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

15049

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15059

1. DECEASED-NAME (Type or Print) First Robert Middle Yourtee Last Campbell			2a. DATE KNOWN OF DEATH Month Oct. Day 21 Year 1968		2b. HOUR 8P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 24 1907	6. AGE (in years last birthday) 60 YRS	IF UNDER 1 YEAR MONTHS 11 DAYS 27	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Md. Washington Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington		9d. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Work			
10. CITY OR TOWN OF DEATH Keedysville RFD 1		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Keedysville Md RFD #1		12b. KIND OF BUSINESS OR INDUSTRY Roads	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Keedysville	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Keedysville Md. RFD #1			
14. FATHER'S NAME First Robert Middle Lee Last Campbell			15. MOTHER'S MAIDEN NAME First Annie Middle May Last Boyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. World War #2 220-10-3578		17. INFORMANT Mrs. John Line	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia of Stomach Contents DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Albert L. Leaf Williamsport, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10-25-68	
EXAMINER'S NAME (Type) Albert L. Leaf Williamsport, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS Albert L. Leaf Williamsport, Md.		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 25-68		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		23d. LOCATION (City or Town) (County) (State) Sharpsburg Wash. Maryland		25a. REC'D BY REGISTRAR OCT 25 1968	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lloyd Albertus Clark						October 6, 1968		6:10P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		Feb. 21, 1903		65 YRS.		MONTHS 7 DAYS 15 HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Beaver Creek, Md.		U. S. A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Machinists		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 3	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William Clark			Florence Poffenberger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No.			705-10-5969		Mrs. Nellie R. Clark, Rfd. 3, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic Carcinoma, (primary site unknown)</u> DUE TO, OR AS A CONSEQUENCE OF (c)									6 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1992 none</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
none				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		City or Town		County State		
				Street or R.F.D. No.						
22a. I certify that (1) (this hospital) attended the deceased from <u>9-19-</u> , 19 <u>68</u> , to <u>Oct 6, 1968</u> , that (1) (we) last saw the deceased alive on <u>Oct 6, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>M.E. Byrkit</u>								<u>10-7-68</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
<u>M.E. Byrkit</u>				<u>Williamport Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
<u>Burial</u>		<u>10-9-68</u>		<u>Rest Haven Cemetery</u>		<u>Hagerstown Wash. Co., Md.</u>				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>John H. Bast, Jr.</u>				<u>112 N. Main St. Boonsboro, Md.</u>		<u>OCT 11 1968</u>		<u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office Block with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) HUBER EMORY EARL CLINGERMAN						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 10-9-1968		2b. HOUR 2:30 P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7/6/1920		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		2c. DATE PRONOUNCED DEAD Month 10 Day 9 Year 1968		2d. HOUR 3:50 P M	
10. CITY OR TOWN OF DEATH INTERSTATE 70 NEAR CLEAR SPRING, MD.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CLERK MACK TRUCKS, INC.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNSYLVANIA COUNTY FULTON				13b. CITY OR TOWN RURAL WARFORDSBURG		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #2			
14. FATHER'S NAME First EMORY Middle CLINGERMAN Last BOOR				15. MOTHER'S MAIDEN NAME First BERTHA Middle BOOR Last BOOR							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO. W.W. 2 159 12 5656		17. INFORMANT IZORA E. CLINGERMAN		ADDRESS RFD #2 WARFORDSBURG, PA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury to chest - rupture DUE TO, OR AS A CONSEQUENCE OF Heart - Bifurcal laceration & (b) Multiple fractures DUE TO, OR AS A CONSEQUENCE OF (c) Multiple fractures										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Trained	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8166											
19a. DATE OF OPERATION 8166				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 10 9 19 68 HOUR A.M. 8 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Rear End collision - Involving Auto					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Inter State Hiway		21f. LOCATION Street or R.F.D. No. Near Clear Spring		City or Town Wash		County MD		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward W. Ditto, III				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 10-10-68			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/13/68		23c. NAME OF CEMETERY OR CREMATORY MAYS CHAPEL CHRISTIAN		23d. LOCATION (City or town) WARFORDSBURG FULTON PA.		(County)		(State)	
24. FUNERAL DIRECTOR HOWARD J GROVE HANCOCK, MARYLAND				ADDRESS				25a. REC'D BY REGISTRAR OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

HOWARD 1 GROVE HARCOCK, MARYLAND

OCT 15 1968

BURIAL 10/13/68 MAYA CHAPEL CHRISTIAN WARFORDSBURG FULTON PA.

WED, 11, 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

15052										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15062									
1. DECEASED-NAME (Type or print)										20. OATE OF DEATH																			
First Hassan Middle Martin Last Connor										Month October Day 25 Year 1968																			
3. SEX Male										4. RACE White																			
5. DATE OF BIRTH October 6, 1912										6. AGE (In years last birthday) 56 YRS.																			
70. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.																			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH Washington Md.																			
10. CITY OR TOWN OF DEATH Hagerstown										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital																			
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor										12b. KIND OF BUSINESS OR INDUSTRY																			
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Washington										13c. CITY OR TOWN Hagerstown																			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 129 West Franklin St.																			
14. FATHER'S NAME First Lester Middle N. Last Connor										15. MOTHER'S MAIDEN NAME First Caroline Middle Martin Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) W.W.2										16b. SOCIAL SECURITY NO. 912-20-2498																			
17. INFORMANT 454 North Prosbank Street										Mrs Gladys M. Leggett																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:										16 days																			
IMMEDIATE CAUSE (a) 1. Pneumonia																													
486X 486X DUE TO OR AS A CONSEQUENCE OF																													
(b) 22. Hepatic cirrhosis										Not known																			
DUE TO OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
493X 493X																													
19a. OATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED																			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19																			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)																			
21f. LOCATION Street or R.F.D. No. City or Town County State																													
220. I certify that (I) (this hospital) attended the deceased from Oct. 2 , 19 68 , to Oct. 25 , 19 68 , that (I) (we) last saw the deceased alive on Oct. 24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE B. B. Kneisley, M.D.										22c. DATE SIGNED 10/25/68																			
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.										22e. ADDRESS 148 West Washington Street Hagerstown, Maryland																			
230. BURIAL, CREMATION, Buried										23b. DATE Oct. 28/68																			
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery										23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland																			
24. FUNERAL DIRECTOR Hagerstown, Md.										ADDRESS Andrew K. Coffman Funeral Home Inc.																			
250. REC'D BY REGISTRAR OCT 28 1968										25b. REGISTRAR'S SIGNATURE J. Charles Judge																			

15062

15062

UNITED STATES OF AMERICA

October 25, 1945	Connor	Martin	Hassan
October 6, 1945	Washington	White	White
Labor	Washington Co. Hospital	U.S.A.	Washington
120 West Franklin St.	Washington	Washington	Washington
Caroline Martin	Connor	Connor	Connor
412-20-2430's Gladys M. Connor	Connor	Connor	Connor

J. P. Connor

Washington Co. Hospital

October 25, 1945
 Washington Co. Hospital
 412-20-2430's Gladys M. Connor
 15062

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First CHARLES			Middle EDWARD			Last CRAMPTON JR.			2a. DATE OF DEATH Month Oct Day 6 Year 1968			2b. HOUR M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH Feb. 23 1919			6. AGE (In years lost birthday) 49 YRS.			IF UNDER 1 YEAR MONTHS 7 DAYS 12		IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.							
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Cement Co.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Washington			13c. CITY OR TOWN Sharpsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Snyders Landing				
14. FATHER'S NAME First Charles			Middle Edward			Last Crampton Sr.			15. MOTHER'S MAIDEN NAME First Aggie			Middle May			Last Swain	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, in Yes (If yes give war or dates of service) World War 2			16b. SOCIAL SECURITY NO. 220-10-1402			17. INFORMANT Mrs. Pauline Crampton			18. SNYDERS LANDING Sharpsburg Md RFD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Weeks Year -																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Multiple emboli																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from June 5 , 19 61 , to Oct 6 , 19 68 , that (I) (we) last saw the deceased alive on Oct 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Joseph Secundari DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													22c. DATE SIGNED 10-7-68			
22d. PHYSICIAN'S NAME (Type) JOSEPH SECUNDARI													22e. ADDRESS Boonsboro Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Oct 9-68			23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery			23d. LOCATION (City or Town) (County) (State) Sharpsburg Washington Md.							
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport Md.													25a. REC'D BY REGISTRAR DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge	

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary			Lucille Daniels			October 28, 1968			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
female		white		9-20-1893			75 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		UAS				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. County Hospital			Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Md.			Wash.		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		935 Greenbriar, Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
E, J. Rutland			Mary F. Harris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					Mr. Kenneth Daniels Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>									19 day
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u>									10 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
443x <u>Arteriosclerosis</u> <u>Auricular Fibrillation</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>68</u> , to <u>10/28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/27/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Robert Vh Campbell M.D.			10/28/68						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Robert T Vh Campbell			145 W WASHINGTON ST						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			10-30-68		Rose Hill Cemetery		Hagerstown, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.			DATE OCT 30 1968			Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

15055										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										15065																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last Mary Edith Darnier										Month Day Year Oct 26 1968										10:40 PM																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH NOVEMBER 19, 1886										6. AGE (In years last birthday) 81 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH WASHINGTON Md.																													
10. CITY OR TOWN OF DEATH HAGERSTOWN										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER										12b. KIND OF BUSINESS OR INDUSTRY OWN HOME																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY WASHINGTON										13c. CITY OR TOWN HAGERSTOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 1317 OAK HILL AVE.																			
14. FATHER'S NAME First Middle Last LOUIS TERNER TURNER										15. MOTHER'S MAIDEN NAME First Middle Last ANNIE R MYERS										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO. 213-48-4164										17. INFORMANT MRS JEANNETTE DANZER HAGERSTOWN, MARYLAND																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Broncho pneumonia (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4200										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute & Chronic pyelonephritis, surgical absence of left kidney																																							
19a. DATE OF OPERATION										19b. CONDITION OR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (1) (this hospital) attended the deceased from 11-30-66 to 10-26-68, that (1) (we) last saw the deceased alive on 10-26-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										22b. SIGNATURE Edwin G Riley, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 10-27-68																																							
22d. PHYSICIAN'S NAME (Type) EDWIN G RILEY, M.D.										22e. ADDRESS WESTERN MARYLAND STATE HOSP., HAGERSTOWN										23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 10/29/68										23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY										23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASHINGTON, MD.									
24. FUNERAL DIRECTOR Charles M. Langer										ADDRESS HAGERSTOWN, MARYLAND										25a. REC'D BY REGISTRAR DATE OCT 30 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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Oct 25 1958

WASHINGTON

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON

Handwritten: Botanical specimens
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Handwritten: Botanical specimens
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Handwritten: Chas. D. Allen, Jr.

10-25-58

OCT 30 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Violet			Susan Davis			October 19 1968			10:40 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		2-2-97			71 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VIRGINIA		UNITED STATES				WASHINGTON Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			Clerk		Hotel	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Hagerstown		YES		140 So Mulberry St
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
BISHOP			DAVIS			Emma Price			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			---		Miss Ena Davis Charles Town W. Va. 25414				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma, Abdomen, Primary Undetermined</u>									
1950 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1992 Arteriosclerotic Heart Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-3</u> , 19 <u>68</u> , to <u>10-19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Domingo A. Garcia</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <u>October 19, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>DOMINGO A. GARCIA</u>								22e. ADDRESS <u>Western Maryland State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/22/68		Edge Hill Cemetery Charles Town W. Va		Jefferson Co			
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE <u>OCT 23 1968</u>		<u>Charles Judge</u>	

15088

TESTIMONY OF DEATH

15088

Hotel

WESTERN N.C. STATE HOSPITAL

INVESTIGATION

140 30 Liberty St

Washington Hagerstown

140 30 Liberty St

15088

Miss Eva Davis Charles Town W. Va.

Box 125

Charles A. Colman Funeral Home Inc.
Hagerstown Md
15088-08 140 30 Liberty St
Washington Hagerstown
Miss Eva Davis Charles Town W. Va.
15088-08 140 30 Liberty St
Washington Hagerstown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 7-58

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
15057										
15067										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR P		
James			William			Dayhoff		Oct. Month 15 Day 1968 7:05 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		11/2/86			81 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.	
Maryland		USA					WASHINGTON			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			General		Fruit Produce		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 5	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Frank			Dayhoff			Martha Baker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			214-09-9886		Mrs. Roberta Dayhoff Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									3 months	
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the lung</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Carcinoma of the bladder</u>									15 years	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Arteriosclerotic cardiovascular disease.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (we) attended the deceased from <u>Oct. 14</u> , 19 <u>68</u> , to <u>Oct. 15</u> , 19 <u>68</u> , that (I) (we) saw the deceased alive on <u>Oct. 15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Chong Choon Han</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/16/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Chong C. Han, M.D.</u>						22e. ADDRESS <u>Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-18-1968		Rose Hill Cemetery		Hagerstown, Md.				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home Hagerstown, Md.						DATE <u>OCT 18 1968</u>		<u>J. Charles Judge</u>		

Figure 2

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1. *Journal of the American Medical Association*, 1990; 263: 1001-1005.

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1142 • J. Neurosci., September 24, 2008 • 28(39):1137–1146

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

804 J. E. H. Smith and others

1992-1993

TABLE 1. *Continued*

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1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15058 | | | | | | | | | | 15068 | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Herbert M. Dolfeld | | | | | 2a. DATE OF DEATH
Month October Day 9 Year 1968 | | | | | 2b. HOUR
1:00P M | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
May 7, 1883 | | | 6. AGE (In years last birthday)
85 YRS. | | | IF UNDER 1 YEAR
MONTHS 5 DAYS 2 | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Washington Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Boonsboro | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rfd. 2 | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Government Employee | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | | 13c. CITY OR TOWN Boonsboro | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Rfd. 2 | | | | | | | |
| 14. FATHER'S NAME First Alexander Middle Y. Last Dolfeld | | | | | 15. MOTHER'S MAIDEN NAME First Emma Middle Last Kroh | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No. (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. None | | | | | 17. INFORMANT Baltimore, Md.
Mrs. Theodore Waters, 117 Tunbridge Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiac vascular disease
4129
DUE TO, OR AS A CONSEQUENCE OF
(b) disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 10, 1968 , to Oct 9, 1968 , that (I) (we) last saw the deceased alive on October 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE G.W. Lelan M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
Oct 9, 1968 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) G.W. Lelan M.D. | | | | | | | | | | 22e. ADDRESS
Boonsboro, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE
9- 11- 68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Boonsboro Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Boonsboro, Wash. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR
OCT 14 1968 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15059

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15069

| | | | | | | | | |
|---|--|---|--------|---|-------------------------------------|--|----------------------|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
5:05 P M | |
| IRA | | ELWOOD | | DOUGLAS | OCT. 26, 1968 | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12/18/1895 | | 6. AGE (In years
at birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign
country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | IF UNDER 24 HRS.
HOURS MIN |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
WASH. CO. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
FAIRCHILD AIRCRAFT | | 12b. KIND OF BUSINESS OR
INDUSTRY
AVIATION | | |
| 13a. USUAL RESIDENCE (Where deceased
lived, if institution: Residence before
admission) STATE
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1615 WABASH AVE |
| 14. FATHER'S NAME
First Middle Last
WILLIAM WATSON DOUGLAS | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY BREWER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
BERTHA A. DOUGLAS 1615 WABASH AVE HAGERSTOWN, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
4339 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 wks
Many
years | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332x <u>arteriosclerotic heart disease</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/15, 19 68</u> , to <u>10/26, 19 68</u> , that (I) (we) last
saw the deceased alive on <u>10/25, 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Charles Judge</u> | | | | DEGREE
ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10/29/68 |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
10/29/68 | | 23c. NAME OF CEMETERY OR CREMATORY
DAMASCUS CHRISTIAN | | 23d. LOCATION (City or Town) (County) (State)
RURAL HANCOCK FULTON, PA. | | |
| 24. FUNERAL DIRECTOR
<u>Richard Lane Hancock, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

10000

CENTRAL OF DEATH

10000

DOT. 50. 1000

DOUGLAS

ELWOOD

IRA

12/18/1905

WHITE

MALE

WASHINGTON

U.S.A.

PENNSYLVANIA

WASH. CO. HOSPITAL

HAGERSTOWN

1015 WABASH AVE

HAGERSTOWN

WASHINGTON

MARYLAND

BRENNER

MARY

WATSON DOUGLAS

ILLIAN

HAGERSTOWN, MD.

BERTHA A. DOUGLAS 1015 WABASH AVE

NO

CAVABUS CHIRYIAN JARU HANOOK BUTON, PA.

10000

10000

NOV 1 1905

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15070

15060

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|-------------------------------|--|
| 1. DECEASED NAME
(Type or print) | | First
RUBY | | Middle
REBECCA | | Last
FLEAGLE | | 2a. DATE OF DEATH
OCTOBER | | 2b. DATE OF DEATH
Month 1 Day 19 Year 1968 | | 2c. HOUR
8:35 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
8/12/1887 | | | | 6. AGE (In years
last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street and city)
ARMY MANOR INC. | | 12a. USUAL OCCUPATION (Kind of work done
during 1 year prior to death, even if retired.)
HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
HOME | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission)
MARYLAND | | 13b. CITY OR TOWN
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
22 NORTH AVE. | | | | | |
| 14. FATHER'S NAME
First Middle Last
BENJAMIN F. LUSHBAUGH | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LILLIE I. BAKER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, NO (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
150-07-5598 | | 17. INFORMANT
MRS. VIOLET BIRDSALL MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral lobular Pneumonia
4339
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. 352x
(b) Advanced Arteriosclerotic Vascular
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes and Cerebral Thrombosis
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes Mellitus | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4-5 days
10-20 yrs | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 13, 1968 to Oct 7, 1968 , that (I) (we) last
saw the deceased alive on Oct 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Edward W. Ditto III | | DEGREE | | ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-2-68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Edward W. Ditto, III, M.D. | | 22e. ADDRESS
217 W. Washington Street
Hagerstown, Maryland | | | | | | | | | | | |
| 23a. BURIAL CREMATION
REMOVED TO
BURIAL | | 23b. DATE
10/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | | | |
| 24. FUNERAL DIRECTOR
W. J. Norment Hagerstown Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE OCT 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

15060

15070

REPORT OF...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15061

CERTIFICATE OF DEATH

15071

| | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) TERRY EDWARD FOUST | | | 2a. DATE OF DEATH
Month OCTOBER Day 27 Year 1968 | | | 2b. HOUR
4 A.M. | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
6/7/1968 | | 6. AGE (In years
lost birthday)
YRS. 4 MONTHS 20 HOURS 20 MIN. | | IF UNDER 1 YEAR
MONTHS 4 IF UNDER 24 HRS.
HOURS 20 MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street and address) WASHINGTON CO. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) INFANT | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
26 E. LONGMEADOW RD. | |
| 14. FATHER'S NAME First Middle Last
DONALD LEE FOUST | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LINDA LOU MILLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, name (unknown) (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT Address
MR. DONALD L. FOUST HAGERSTOWN MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sub-dural Hematoma
039.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. 064.4
(b) Meningitis due to Para Col. locillus
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia due to (H) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Not known
probably around day
1800p
1800p | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Resolving R.V. Pneumonia terminal atelectasis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes in agreement with Coroner | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/10 , 19 68 , to 10/27 , 19 68 , that (I) (was) last
saw the deceased alive on 10/26/68 at 2 AM , and that in (my) (own) opinion death occurred on the date and hour and from the
causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
A. M. Bacon, Jr. M.D. DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | | 22c. DATE/SIGNED
10/28/68 | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) A. M. Bacon, Jr., M. D. | | | | 22e. ADDRESS
101 KING ST. HAGERSTOWN MD. | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Type) BURIAL | | 23b. DATE
10/29/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest HAVEN CEM. | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | | |
| 24. FUNERAL DIRECTOR
W. J. Norman, Hagerstown, Md. ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE OCT 30 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

81-116641

10001

10001

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 1, 1901

ALBANY: JAMES BRONKHORST, STATE PRINTER, 1901

RECEIVED JAN 1 1901

OFFICE OF THE COMMISSIONERS OF THE LAND OFFICE

ALBANY, N. Y.

1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| 15062 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15072 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Hillard W French | | | | | | | | | | Month Day Year
October 31 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | September 11, 1904 | | | | | | | | | | 64 | | | | | | | | | | YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Big Pool, Md. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | | | | | | Washington Co. Hospital | | | | | | | | | | Contractor | | | | | | | | | | Paint & Glass | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | | Hagerstown | | | | | | | | | | YES | | | | | | | | | | 1049 Beechwood Drive | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William Howard French | | | | | | | | | | Christianne Kline | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | 214-09-8430 | | | | | | | | | | Mrs. Mabel E. French | | | | | | | | | | 1049 Beechwood Drive | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | Nervia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | 34 hrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4120 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Nephrosclerosis | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Cerebrovascular Cardio. DE. | | | | | | | | | | years. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | At myocardial infarct, Diabetes, Cerebral & liver. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 Sept 68, to date, 1968, that (I) (we) last saw the deceased alive on 31 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford | | | | | | | | | | 1 Nov 68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type or print) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 11/3/68 | | | | | | | | | | Rest Haven Cemetery | | | | | | | | | | Hagerstown-Washington Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wm. G. Harp | | | | | | | | | | NOV 4 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rest Haven Funeral Chapel | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

15073

15073

SEARCHED

INDEXED

SEPTEMBER 11, 1963

WHITE

WHITE

WASHINGTON

WASHINGTON

DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

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WASHINGTON

214-30-4470

NO

15073

NOV 4 1963

15073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15063 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15073 | | | | | | | | | |
|---|--|--|--------------|--|--|------------------|--|--|---------------------------------|--|--|------------------------|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
WAID COLIER FRIDY | | | | | | | | | | Month Day Year
October 6 1968 | | | | | | | | | | HRS. MIN.
5:52 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| MALE | | | NEGRO | | | 2-1-1880 | | | 88 YRS. | | | MONTHS DAYS HOURS MIN. | | | MONTHS DAYS HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| N. CAROLINA | | | | | U.S. | | | | | | | | | | WASHINGTON Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| HAGERSTOWN | | | | | WESTERN MD. STATE HOSPITAL | | | | | | | | | | MAINTENANCE | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Rt. #1 Mt. Airy | | | | | Frederick | | | | | MT Airy | | | | | YES | | | | | 12#1 Mt. Airy | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| UNKNOWN | | | | | FRIDY | | | | | ANNE | | | | | NMM FLUNGOLANER | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| NO | | | | | 579-14-1957 | | | | | LOVATA PINKET Rt1 Mt. Airy md | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Many years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/2 , 19 68 , to 10/6 , 19 68 , that (I) (we) last saw the deceased alive on Oct. 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Fe U. Porciuncula M.D. | | | | | | | | | | 22c. DATE SIGNED Oct. 6, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) FE U. PORCIUNCULA | | | | | | | | | | 22e. ADDRESS Western Maryland State Hospital | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| REMOVAL | | | | | 10-10-68 | | | | | Evergreen | | | | | Winston Salem Forsyth N.C. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| C.E. HICKS, III Frederick, md | | | | | | | | | | OCT 10 1968 | | | | | Charles Judge | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

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CRIMINAL RECORDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|-------|---|--|--------------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15066 | | | | | 15074 | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| ELSIE | | ANN | | GARNAND | | OCT. 24 1968 | | 2b. HOUR
7 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | March 9 1878 | | 90 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Md.
Garfield Fred. | | U.S.A. | | Washington | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Hagerstown | | Washington County Hospt. | | House Wife | | Home | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Washington | | Smithsburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R. F. D. #2 | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| Simon | | P | | Kuhn | | Amelia Harrison | | Address | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| no | | no | | Robert Kuhn | | Smithsburg RFD.#2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
180X
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of cervix with metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 weeks
18 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-8, 1960, to 10-24, 1968, that (I) (we) last
saw the deceased alive on 10-23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| Charles F. Hess | | 10-24-68 | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Charles F. Hess, M.D. | | Smithsburg, Maryland 21783 | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | Oct. 27 68 | | Cavetown Reform Cemetery | | Cavetown | | Wash. Md. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MINNICH FUNERAL HOME | | SMITHSBURG MD. | | OCT 28 1968 | | j Charles Judge | | | |

1507

2000

RECEIVED BY FUNERAL HOME, SPRINGFIELD, MO.

\$29,950.00

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15065

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25075

| | | | | | | | | |
|--|-------------------------|--|---|--|--|---|---------------------------------|---|
| 1. DECEASED-NAME
(Type or Print) JOSEPH HAROLD GEARHART | | | 2a. DATE KNOWN OF DEATH MATED OCT. 17 68 | | | 2b. HOUR 9:15 PM | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
5/10/1914 | 6. AGE (In years, months, days)
54 YRS. | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | IF UNDER 24 HRS
HOURS _____ MIN _____ | 2c. DATE PRONOUNCED DEAD
Month OCT. Day 17 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
325 S. MULBERRY ST. | | 12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if retired.)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
GRAIN MILL | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
325 S. MULBERRY ST. |
| 14. FATHER'S NAME
First JACOB Middle ALBERT Last GEARHART | | | 15. MOTHER'S MAIDEN NAME
First ELLA Middle REARL Last HOFFMAN | | | 16. ADDRESS
BALTIMORE MD. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or unknown) NO | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
MR. LLOYD L. GEARHART | | | ADDRESS
BALTIMORE MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 Acute Congestive heart failure due to
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic heart Disease and
DUE TO, OR AS A CONSEQUENCE OF
(c) Early Bilateral Cerebral infarction | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs?
2-3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4200 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ State _____ |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III | | | M.D. Edward W. Ditto, III, M.D. | | | 22b. DATE SIGNED
10-18-68 | | |
| EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) | | | 217 W. Washington St. Hagerstown, Maryland | | |
| 23a. BURIAL, CREMATION, or other disposition
BURIAL | | 23b. DATE
10/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. PAULS CEM. | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON CO. MD. | | |
| 24. FUNERAL DIRECTOR
W. J. Normant, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR
DATE OCT 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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17 OCT 1968

17 OCT 1968

WASHINGTON

U.S.A.

KAYLAND

327 S. MURPHY ST.

WASHINGTON

327 S. MURPHY ST.

WASHINGTON

HONOLULU

PEARL

SEA

GEORGE

BOAT

WASHINGTON

MR. DAVID L. GEORGE

NO

OCT 23 1968

ST. PAULS CHURCH

1/21/68

RECEIVED

U.S. Government Printing Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardbox papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
30M REV 1/68

15068

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15076

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) SAMUEL LESHNER GEIST | | | 2a. DATE OF DEATH
Month October Day 16 Year 1968 | | | 2b. HOUR
P 7 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Dec 29 1884 | | 6. AGE (In years last birthday)
83 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash County Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Foreman M.P. Moller | | 12b. KIND OF BUSINESS OR INDUSTRY
Co Retired | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. CITY OR TOWN
Washington Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
828 Salem Ave | |
| 14. FATHER'S NAME First Middle Last
Isaac Geist | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Leshner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) -- | | 16b. SOCIAL SECURITY NO.
217-01-1533 | | 17. INFORMANT Address
Mrs Cora M. Weaver 828 Salem Ave Hagerstown Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 403 X Uremia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 445 X (b) Nephrosclerosis.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-6 wks. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerosis generalized; acute aneurysm Thoracic | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950 , to death 19 , that (I) (we) last saw the deceased alive on 10-15 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert F. Keagle DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
10-16-68 | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT F. KEAGLE | | | | | | 22e. ADDRESS
Hagerstown Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Wash Co Md | |
| 24. FUNERAL DIRECTOR
Andrew K. Coffman | | | | F
Funeral Home Inc | | 25a. REC'D BY REGISTRAR
DATE OCT 18 1968 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

15075

ORIGINAL DESIGN

SAHUEL

LESTER

GAIST

October 16 1968

Male

White

Dec 29 1894

83

Maryland

U.S.A.

Washington

Hagerstown

Wash County Hospital

Foreman R.F. Miller Co. advised

Maryland

Washington Hagerstown

828 S. Main Ave

Isaac Gaist

Mary Lester

217-01-1533 Mrs. Cora M. Weaver 828 S. Main Ave

Hagerstown Md.

No

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Funeral Home Inc. 11/15/68 Rose Hill Cemetery - Hagerstown Wash Co Md

Andrew K. Collins Funeral Home Inc

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15067

15077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) EVERETT | | | First LOUIE | | | Middle GONYOU | | | Last | | | 2a. DATE OF DEATH
Month 2 Day 68 Year | | | 2b. HOUR 12:30 MIN M | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
APRIL 4, 1891 | | | 6. AGE (In years lost birthday)
77 YRS. | | | IF UNDER 1 YEAR
MONTHS 77 DAYS 77 HOURS 77 MIN. | | | IF UNDER 24 HRS.
HOURS 77 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
MASSACHUSETT | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
AVALEN MANOR NURSING HOME | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETIRED ARCHITECT | | | 12b. KIND OF BUSINESS OR INDUSTRY
ACHETECTURAL FIRM | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
WASHINGTON | | | 13c. CITY OR TOWN
HAGERSTOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1200 OAKHILL AVENUE | | | | | |
| 14. FATHER'S NAME
First ULIRICH | | | Middle GONYOU | | | Last JESSIE | | | 15. MOTHER'S MAIDEN NAME
First FOSTER | | | Middle FOSTER | | | Last FOSTER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
216-16-2768A | | | 17. INFORMANT
MRS ZAZEL GONYOU | | | 1200 Address OAK HILL AVE. | | | HAGERSTOWN, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
4339
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Arteriosclerosis - Gen.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo.
3 yrs. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
332 X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug. 26, 1966 , to Oct 2, 1968 , that (I) (we) last saw the deceased alive on Oct 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Lloyd A. Hoffman DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 10/2/68 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D. 22e. ADDRESS 214 N. POTOMAC ST., HAGERSTOWN, MD. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
10/4/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN, WASHINGTON, MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Charles S. Rauter | | | ADDRESS
HAGERSTOWN, MARYLAND | | | 25a. REC'D BY REGISTRAR
DATE OCT 7 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)
30M REV. 1/68

| MIDDLE | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 15068 | | | | | | | | | | | | |
| 15078 | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Alice | | | First May | | | Last Haffner | | | 2a. DATE OF DEATH
Month October Day 30 Year 1968 | | 2b. HOUR
7:10 M | |
| 3. SEX
female | | | 4. RACE
white | | | 5. DATE OF BIRTH
11-30-1870 | | | 6. AGE (In years
last birthday) 97 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) Penna. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) 112 W. Howard St. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN
Hagerstown | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
112 W. Howard St. | |
| 14. FATHER'S NAME
First Daniel Middle Johnston Last | | | 15. MOTHER'S MAIDEN NAME
First Mary Middle Bowman Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
195-16-4322 | | | 17. INFORMANT
Address Mrs. Jeannette Grove, Hagerstown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with Short
DUE TO, OR AS A CONSEQUENCE OF coronary occlusion duration
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 Acute bronchitis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 24, 1968 , to Oct. 30, 1968 , that (I) (we) last
saw the deceased alive on October 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
B. B. Kneisley M.D. | | | DEGREE M.D. | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
10/30/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type) B. B. Kneisley, M.D. | | | 22e. ADDRESS
148 West Washington Street
Hagerstown, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) burial | | | 23b. DATE
11-2-68- | | | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Waynesboro, Pa. | | | |
| 24. FUNERAL DIRECTOR
Grove Funeral Home, Waynesboro, Pa. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE NOV 4 1968 | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

15078

CONTINUED FROM PAGE 15077

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15069

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15079

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) MATTIE ESTELLE HAMILL | | | 2a. DATE OF DEATH
Month 4 Day 68 Year 1968 | | | 2b. HOUR 9:10 MIN M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
APRIL 6, 1889 | | 6. AGE (In years last birthday)
79 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
323 W. WILSON BLVD. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
323 W. WILSON BLVD. | | | | | | | |
| 14. FATHER'S NAME First Middle Last
FRANK DIETZ | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ISABELLA EVANS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT Address
GEORGE HAMILL, 127 S LOCUST, HAGERSTOWN, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
486X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
493X Cerebral thrombosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from May 1968 , to 8-1-68 , that (I) (we) last saw the deceased alive on 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles C Spencer | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10/5/68 | |
| 22d. PHYSICIAN'S NAME (Type)
CHARLES C SPENCER, M.D. | | | | 22e. ADDRESS
145 S PROSPECT ST., HAGERSTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
10/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN, WASHINGTON, MD. | |
| 24. FUNERAL DIRECTOR
Charles M. Rausser | | | | ADDRESS
HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
DATE OCT 9 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15070

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15080

| | | | | | | | | |
|---|----------------------|--|--|--|---|--|--|---|
| 1. DECEASED-NAME (Type or Print) Frank Joseph Heinle | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> 10 Day <input checked="" type="checkbox"/> 12 Year <input checked="" type="checkbox"/> 1968 | | | 2b. HOUR <input checked="" type="checkbox"/> 5:10 PM | | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH OCT. 10, 1900 | 6. AGE (in years last birthday) 68 YRS. | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> 10 Day <input checked="" type="checkbox"/> 12 Year <input checked="" type="checkbox"/> 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) BALTO., MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | | |
| 10. CITY OR TOWN OF DEATH PEN MAR | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PENNERVILLE RD. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY AMOCO. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 737 S. CONKLING ST. #24. | |
| 14. FATHER'S NAME First FRANK Middle HEINLE Last HEINLE | | | 15. MOTHER'S MAIDEN NAME First THERESA Middle SELIG Last SELIG | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | |
| 16b. SOCIAL SECURITY NO. 213-05-4979 | | | 17. INFORMANT FRANCES K. HEINLE | | | 17b. ADDRESS 737 S. CONKLING ST. BALTO., MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4109
(b) Atherosclerosis, generalized and
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerotic Heart Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-10 yrs | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto III, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 10-12-68 | | |
| EXAMINER'S NAME (Type) 217 W. Washington St. Hagerstown, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 10-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. | | 23d. LOCATION (City or Town) (County) (State) 7401 GERMAN HILL RD. BA. CO., MD. | | |
| 24. FUNERAL DIRECTOR Charles S. Zeiler | | | ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD. | | | 25a. REC'D BY REGISTRAR OCT 17 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

45070

15080



OCT 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-58

| <div> <div>15071</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>CERTIFICATE OF DEATH</div> <div>15081</div> </div> | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--------------------------------|
| 1. DECEASED-NAME (Type or print) ARTHUR DAVID HERBERT | | | | | | 2a. DATE OF DEATH October 2, 1968 | | | 2b. HOUR 7:10 <small>AM</small> | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH January 26, 1881 | | | 6. AGE (In years lost birthday) 87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Martin Manor Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant | | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 523 W. Franklin St | | | |
| 14. FATHER'S NAME David Herbert | | | | 15. MOTHER'S MAIDEN NAME Anna Yost | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 218-30-9669 | | 17. INFORMANT Russell Herbert | | | | Address 1540 Latchford Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4129 IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Hacienda Hgts California
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1- , 19 64 , to 10-2- , 19 68 , that (I) (we) last saw the deceased alive on 7-20- 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A. W. Ditte, Jr. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Oct. 2, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditte, Jr. | | | | | | 22e. ADDRESS 215 W. Washington St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE October 4/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland. | | | | | |
| 24. FUNERAL DIRECTOR Hagerstown, Maryland
Andrew K. Coffman Funeral Home Inc. | | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 7 1968 | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | | | |

18081

18081

ARTHUR

DAVID

HERBERT

October 2, 1908

January 23, 1901

White

Male

Maryland

U.S.A.

x

Washington

Hagerstown

Artin Manor Nursing Home

Merchant

Resident

Maryland

Washington Hagerstown

x

223 W. Franklin St

David Herbert

Anna Vost

115-30-9009

Russell Herbert

Hacienda Alta, California

International Central Laundry, Los Angeles

Burial

October 4, 1908

Andrew A. Collins Funeral Home Inc.

OCT 1 1908

Hagerstown, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 15072 | | | | | 15082 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | |
| First Middle Last
Walter W. Hollinger | | | | | Month Day Year
October 29 1968 7:05 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | April 6 1890 | | 78 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Franklin Co. Pa. | | USA. | | | | Washington Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Washington Co. Hospital | | Railroader | | Penn. Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Penn. | | Franklin | | Greencastle | | YES | | 214 N. Allison St. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| David Hollinger | | | Annie Palmer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 716-09-3847 | | Engle M. Hollinger, Greencastle, Pa. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> | | | | | | | | | 2 hrs. |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | 10 yrs. |
| (b) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 4331 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 11, 1964, to October 29 1968, that (I) (we) last saw the deceased alive on October 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| William C. Brewer, M.D. | | | | | Greencastle, Pennsylvania 17225 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11-1-1968 | | Cedar Hill Cemetery | | Greencastle Franklin Penna | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. RECEIVED BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Harold H. Zimmerman, Greencastle, Pa. | | | | | NOV 4 1968 | | Charles Judge | | |

15083

15083



15083

15083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15073 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15083 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| IVA | | | | | | | | | | OCTOBER | | | | | | | | | | 7:30 P M | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | |
| FEMALE | | | | | | | | | | WHITE | | | | | | | | | | JULY 2, 1891 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| MARYLAND | | | | | | | | | | U.S.A. | | | | | | | | | | WASHINGTON | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | |
| HAGERSTOWN | | | | | | | | | | WASHINGTON COUNTY HOSP. | | | | | | | | | | HOMEMAKER | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | |
| MARYLAND | | | | | | | | | | WASHINGTON | | | | | | | | | | HAGERSTOWN | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | | | | | |
| JOSEPH P. TRUMPOWER | | | | | | | | | | CATHERINE | | | | | | | | | | NO | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | 18. ADDRESS | | | | | | | | | |
| 213-12-7093T | | | | | | | | | | MR. FORREST HOOVER | | | | | | | | | | 56 E. BALTIMORE ST. HAGERSTOWN, MARYLAND | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | instant | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 | | | | | | | | | | (b) Coronary heart disease | | | | | | | | | | 2 yrs | | | | | | | | | |
| | | | | | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chronic heart disease, initial insufficiency, Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from Oct 17, 1966, to Oct 17, 1968, that (I) (we) last saw the deceased alive on July 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| EDSON B. MOODY, M.D. | | | | | | | | | | 10/14/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 363 CLEVELAND AVE., HAGERSTOWN, MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| BURIAL | | | | | | | | | | 10/15/68 | | | | | | | | | | ROSE HILL CEMETERY | | | | | | | | | |
| 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HAGERSTOWN, WASHINGTON, MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Charles M. Rouger | | | | | | | | | | HAGERSTOWN, MARYLAND | | | | | | | | | | DATE OCT 16 1968 | | | | | | | | | |

15033

15033

15033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------------------|--|--|-------------------|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| Item 8 Film G405 10/17/68 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| MOLLIE G. INGREAM | | | | | | Oct 11 1968 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| F | | White | | June 10, 1882 | | | 86 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Franklin | | U.S.A. | | | | Washington Co Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown Md | | | Washington Co | | | Housekeeper | | | Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md | | | Washington | | Hagerstown | | YES | | 254 S Tolomae St | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Samuel | | | Hannan | | | Catherine Tachellm | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | No | | | Orland L. Ingream Jr | | | Greenacres Pa | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction | | | | | | | | | | | 1 day | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| Carcinoma of breast with metastasis to axilla, Nephrosclerosis. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 Oct 68, 19 to 11 Oct 1968, that (I) (we) last saw the deceased alive on 10 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | 22c. DATE SIGNED | | | |
| Richard T. Binford | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | |
| Richard T. Binford, M.D | | | | | | Hagerstown, Md 21740 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | | Oct 14 1968 | | | Cedar Hill Cemetery | | | Near Greenacres Pa | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.E. McQuinn | | | Greenacres Pa | | | DATE OCT 15 1968 | | | Charles Judge | | | |

MEDICAL CERTIFICATION

X

1000000

1000000

1000000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, and file it with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15075

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15085

| | | | | | | | |
|---|-------------------------|--|---|--|-------------------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) First Middle Last
LEAVITT JAMISON | | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 10 7 1968 | | | 2b. HOUR
10 ⁰⁰ P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Nov. 29, 1921 | 6. AGE (In years last birthday)
46 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year 10 8 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Sharpsburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Residence | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
General | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Sharpsburg | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
221 W. Antietam St. | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Philip Noah Jamison | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Agnes Savilla Ingrgam | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
220-09-7481 | | 17. INFORMANT ADDRESS
Thurman Jamison 211 W. Main St., Sharpsburg, Md. 21782 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5718 Portal cirrhosis & hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Bilateral lobular pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Est. 3-5 days. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
5810 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Edward W. Ditto III, MD | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Edward W. Ditto III, MD | | ADDRESS (Street, city, town, or county)
217 W. Washington St., Hagerstown, Md. 21740 | | 22b. DATE SIGNED
10-9-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Oct. 11, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Samples Manor Cemetery, Samples Manor, Wash., Md. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
H. Donald Eickler | | ADDRESS
Harpers Ferry, W. Va. | | 25a. REC'D BY REGISTRAR
OCT 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

15085

15085

15085

JAMES J. JAMES

James J. James, 1911

Washington

James J. James

James J. James, 1911

James J. James

James J. James

James J. James, 1911

James J. James, 1911

James J. James, 1911

James J. James, 1911

James J. James, 1911

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James J. James, 1911

James J. James, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
30M REV. 1-7-68

| 15076 | | | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | 15086 | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) Gladys Irene Jones | | | | 2a. DATE OF DEATH
Month 10 Day 25 Year 68 | | | | 2b. HOUR 3:45 A M | | | |
| 3. SEX Female | | 4. RACE American | | 5. DATE OF BIRTH 2-25-1894 | | 6. AGE (In years lost birthday) 74 YRS. | | 7. UNDER 1 YEAR MONTHS 03 DAYS 2 | | 8. UNDER 24 HRS. HOURS 03 MIN 2 | |
| 7a. BIRTHPLACE (State or foreign country) Erie, PA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Williamsport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport Sanitarium | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Resident before admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 244 Walgrave Road | | | |
| 14. FATHER'S NAME First Frank Middle Lealand Last Heegel | | 15. MOTHER'S MAIDEN NAME First Margaret Middle Ellen Last Heegel | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 216-54-1461 | | 17. INFORMANT Mrs. Althea Ritter Address 244 Walgrave Rd Reisterstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral embolus
4274
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4337
(b) Auricular fibrillation with embolic shower
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Embolic occlusion of left femoral Artery | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County, State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-9 , 19 66 , to 10-25 , 19 68 , that (I) (we) last saw the deceased alive on 10-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. E. Byrkit, M. D. | | | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Oct. 25, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) M. E. Byrkit, M. D. | | | | 22e. ADDRESS Williamsport, Maryland 21795 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Oct. 28, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. Woodlawn, Balto. Co., Md. | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR H. J. Edhardt ADDRESS Owings Mills, Md. | | | | 25a. REC'D BY REGISTRAR OCT 28 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

2025

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

[Illegible text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

15077

15087

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Washington County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Massachusetts b. COUNTY Plymouth | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Ritchie, Maryland | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Big Sandy Pond, Plymouth, Mass. | | | |
| c. LENGTH OF STAY IN 1b
DOA | | | | d. STREET ADDRESS
Central Ave. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
US Army Dispensary, Fort Ritchie, Md. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Mitchell | | | 4. DATE OF DEATH
Month October Day 10 Year 19 68 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Caucasian | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
28 June 1911 | |
| 9. AGE (in years last birthday)
57 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor | | 11. BIRTHPLACE (County & State, or foreign country)
Bristol Co., Mass. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Fabric Mill | | | |
| 13. FATHER'S NAME
Stephan Karczmarsczek | | | | 14. MOTHER'S MAIDEN NAME
Frances Slankiewicz | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
015-108639 | | 17. INFORMANT
CDR Eugene E. Sheehy, Ft. Ritchie, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4100
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Cardiovascular Disease
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
5 min. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
4201 None | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 PM , 19 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 2:20 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Delbert L. Secrist, Jr., M.D. | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10 Oct 68 | |
| 22c. PHYSICIAN'S NAME (Type)
DELBERT L. SECRIST, JR., CPT, MC | | | | 22d. ADDRESS
US Army Dispensary, Fort Ritchie, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/14/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | 23d. LOCATION (City, town or county) (State)
New Bedford, Bristol Co., Mass. | |
| 24. FUNERAL DIRECTOR
Walter Z. Goss | | | | 25a. REC'D BY REGISTRAR
Waynesboro, Penna. | | 25b. REGISTRAR'S SIGNATURE
OCT 18 1968 | |

15027

15027

15027

15027

Central Ave.

Central Ave.

Central Ave.

Central Ave.

27

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

Princeton Co., Mass.

15027

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Princeton Co., Mass.

Princeton Co., Mass.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15078

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15088

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
William (no) Kears | | | 2a. DATE OF DEATH Month Day Year
Oct 25 1968 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
Colored | | 5. DATE OF BIRTH
Dec 11 1914 | | 6. AGE (In years last birthday) YRS.
53 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Olar, S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington County Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
135 W. Bethel Street | |
| 14. FATHER'S NAME First Middle Last
Jake Kears | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Stroman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
712-01-0139 | | 17. INFORMANT Address
Mrs. Mary L. Kears 135 W. Bethel St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cerebrovascular Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Obesity</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4100</u>
<u>4201</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 Hrs.</u>
<u>not known</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>68</u> , to <u>10-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Arturo Riego</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10-25-68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>ARTURO RIEGO</u> | | 22e. ADDRESS
<u>119 E. Antietam St</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Oct 29 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Wash. Maryland | | | |
| 24. FUNERAL DIRECTOR
<u>John R Watson of Hagerstown Md</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 29 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

12088

12088

1

12088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15079

15089

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) JAMES | | | First FRANKLIN | | | Middle KEYES, JR. | | | Last | | | 2a. DATE OF DEATH
Month 23 Day 68 Year | | | 2b. HOUR
10:45 M | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
APRIL 4, 1925 | | | 6. AGE (In years
lost birthday)
43 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) 2300 ROCKCLIFFE DR. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
CHARGE OF SECURITY | | | 12b. KIND OF BUSINESS OR
INDUSTRY FAIRCHILD | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | | 13c. CITY OR TOWN
HAGERSTOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2300 ROCKCLIFFE DR. | | | | | | | | | | | |
| 14. FATHER'S NAME
First JAMES Middle F Last KEYES, SR. | | | 15. MOTHER'S MAIDEN NAME
First HELENA Middle JOYCE Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) YES (If yes give war or dates of service) WW 2 | | | | | | | | | 16b. SOCIAL SECURITY NO.
219-18-6484 | | | 17. INFORMANT
MRS. JEAN KEYES | | | 2300 Address ROCKCLIFFE DR.
HAGERSTOWN, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Metastases
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Carcinoma of Lung, Bronchogenic
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
8 weeks
6 mo | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1621 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/12 , 19 68 , to 10/23 , 19 68 , that (I) (we) last
saw the deceased alive on 10/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE J. Martin, MD. DEGREE MD. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> 22c. DATE SIGNED 10/24/68 | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) DONALD E. MARTIN, M.D. 22e. ADDRESS 363 CLEVELAND AVE., HAGERSTOWN, MD. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | 23b. DATE
10/28/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE CITY MARYLAND | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Charles Rouger ADDRESS HAGERSTOWN, MARYLAND 25a. REC'D BY REGISTRAR OCT 30 1968 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | | | | | | | | | | | | | | | |

13052

13052

13052

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15080

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15090

| | | | | | | | | | | | | |
|--|---------|--|--|---|---|---|--|--------------------------|--|----------|---|----------|
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | | |
| Harry Luther King | | | | | | Month Day Year | | | | 11:38 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR |
| Male | White | Jan 19, 1906 | 62 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | | | | 12:00 PM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| West Virginia | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Washington | | | | | | MD. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Hagerstown | | Wash. Co. Hospital | | Foreman | | Masonry | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. STREET AND NUMBER | | | | | | | | |
| Maryland | | Washington | | 14 Mulberry St. | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Samuel King | | | Meta Sterling | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | 214-05-7584 | | | Mrs. Dorothy King Clear Spring, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushing injury to chest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>and Multiple traumatic injuries</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Turned</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | 11:15 PM 10-15-68 | | Struck by Auto while working in street | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION (Street or R.D. No.) City or Town County State | | | | | | | |
| | | | Street | | Fredericks St. Hagerstown Wash Md | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | | |
| Edward W. Ditto III | | | | | | 10-17-68 | | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | | | | |
| Edward W. Ditto, III, M.D. | | | | | | 217 W. Washington St. Hagerstown, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | | | | | | |
| Burial | | Oct. 18, 68 | | Cedar Lawn Memorial | | Hagerstown Wash. Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Thompson Funeral Home Clear Spring, Md | | | OCT 21 1968 | | | Charles Judge | | | | | | |

15000

15000

Harry Foster King

John White Jan 19, 1900

West Virginia U.S.A.

Hagerstown Wm. Co. Hospital

Hagerstown Clear Spring

Clear Spring

214-02-7500

John White

John White

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 15081 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 15091 | |
|---|---------|------------------|--|------------------------------------|--|---|--|--------------------------|---|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 20. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month Day Year | | 2b. HOUR |
| CHA RLES GILBERT KOUNTZ | | | | | | 10 6 1968 | | | 4:15 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | Apr. 11, 1908 | | 60 YRS. | | | | Month Day Year | | 5:10 PM | |
| 70. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Penna. | | | U.S.A. | | | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Nr. Hagerstown | | | Western Pike | | | Supervisor of Lab. | | | Fairchild-Hiller Corp | | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Maryland | | | Washington | | | Nr Hagerstown | | | R # 2 | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | |
| Charles Edward Kountz | | | | | | Ethel Spurgeon | | | | | |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no; or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | | | | Mrs. Virginia Kountz, R # 2 | | | Hagerstown Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration foreign Body (Meat)</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>911X</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1-5 Min.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>9210</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
<u>4:45 P.M. 10 6 1968</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>choked while eating piece meat</u> | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<u>Home</u> | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>RT #2 Nr. Hagerstown Wash Md</u> | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | Edward W. Ditto, III, M.D. | | | | | | 22b. DATE SIGNED
<u>10-7-68</u> | | |
| EXAMINER'S
NAME (Type) | | | 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | | | 23b. DATE | | |
| | | | Burial Oct. 9, 1968 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | |
| | | | Cedar Lawn Cemetery | | | | | | 23d. LOCATION (City or Town) (County) (State) | | |
| | | | Hagerstown, Maryland. | | | | | | 24. FUNERAL DIRECTOR | | |
| | | | Hagerstown, Maryland | | | | | | 25a. REC'D BY REGISTRAR | | |
| | | | A Andrew K. Coffman Funeral Home Inc. | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | DATE OCT 10 1968 | | | | | | <u>Charles Judge</u> | | |

15081

15081

CHAS RILEY GILBERT KNIGHT

Male White A. 11, 1903 Oct 6

Penn. U.S.A. Washington

Mr. Hagerstown Western like Supervision of Rev. Luther C. Miller

Maryland Washington Mr. Hagerstown K. W. S.

Charles Edward Knight Ethel Spurgeon

no Mrs. Virginia Knight, 10 Hagerstown

Burial Oct. 9, 1908 Cedar Lawn Cemetery

Hagerstown, Maryland
Andrew T. Coffman Funeral Home Inc.

Oct 10 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15082 | | | | | | | | | | 15092 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| MAMIE MAE SINGHAS LEE | | | | | | | | | | 10/20/68 | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | |
| 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost month day) | | | | | | | | | |
| Oct. 26, 1892 | | | | | | | | | | 75 YRS. | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| USA | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| Washington County | | | | | | | | | | Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | |
| Hagerstown | | | | | | | | | | Washington Co. Hospital | | | | | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Housewife | | | | | | | | | | Own Home | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | |
| Hagerstown | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 13e. STREET AND NUMBER | | | | | | | | | | 13f. STREET AND NUMBER | | | | | | | | | |
| 276 S. Prospect St. | | | | | | | | | | 276 S. Prospect St. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Thomas H. Singhas | | | | | | | | | | Josephine Mullen | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| no | | | | | | | | | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | |
| Son: Robt. C. Lee, Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Embolus Myocardial Infarction | | | | | | | | | | 2 Days | | | | | | | | | |
| 2509 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 260x | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| | | | | | | | | | | Arteriosclerotic & Pulmonary | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13/68, 19, to 10/20/68, 19, that (I) (we) last saw the deceased alive on 10/20/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| William O. Ryde | | | | | | | | | | 10/21/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| Burial | | | | | | | | | | 10/23/68 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Green Hill Cem. | | | | | | | | | | Berryville, Virginia | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | |
| B. J. Ender | | | | | | | | | | DATE OCT 25 1968 | | | | | | | | | |
| ADDRESS | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Berryville, Va. | | | | | | | | | | Charles Judge | | | | | | | | | |

230

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | | |
|---|--|--|--------|---|---|---|--|--------------------------------|--------------------------------|--|
| MARTHA ELLEN LEWIS | | | | | October 11, 1968 | | 8:30p | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
October 27, 1879 | | 6. AGE (In years last birthday)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Frederick, Co. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington County Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Rural Smithsburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Own Home | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Smithsburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME
Hanson | | First
C. Draper | | 15. MOTHER'S MAIDEN NAME
Mary Jane Weddle | | First
Middle
Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
Lost | | 17. INFORMANT
Mrs. Helen M. Swope Smithsburg, Md. | | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart disease Arteriosclerotic</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 mos</u>
<u>5 yrs</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>4200 Cholecystitis - Chronic</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 63 to Oct 11 19 68, that (I) (we) lost saw the deceased alive on Sept 14 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
James K. Gray M.D. | | DEGREE | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Oct. 12-1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. James K. Gray | | 22e. ADDRESS
Thurmont, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Oct. 15, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Bethel Methodist | | 23d. LOCATION (City or Town) (County) (State)
Foxsville Frederick Md. | | | | |
| 24. FUNERAL DIRECTOR
Raymond E. Creager | | ADDRESS
Thurmont, Maryland | | 25a. REC'D BY REGISTRAR
DATE
Oct 18 1968 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | | |

1000

1000



1000



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 15084 | | | | | | | | | | 15094 | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|---------------------------------|--|-----------------|--|--|--|--------------------------|--|--|---|--|----------|--|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | | | First Middle Last | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| Ervin | | | | | Nethkins | | | | | MacDonald | | | | | 10-5-1968 10 PM | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | | | 2d. HOUR | | | | | | | | | | | | |
| Male | | White | | Aug. 6, 1901 | | 67 YRS. | | MONTHS DAYS | | HOURS MIN | | 10 5 Year 1968 | | | | | 10 PM | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | B. MARRIED | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| West Virginia | | | | | U S A | | | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | Washington Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Hagerstown | | | | | Washington County Hospital | | | | | Retired Car Inspector | | | | | Erie R R | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | Allegany | | | | | Cumberland | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 732 Maryland Avenue | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | | | | | |
| William | | | | | Z. MacDonald | | | | | Sena | | | | | Haslacker | | | | | ADDRESS Winchester Road | | | | | | | | | |
| No | | | | | (If yes give war or dates of service) | | | | | 198-16-2680 | | | | | Rob't B. MacDonald, Route 5, Cumberland, Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion - | | | | | | | | | | | | | | | Turned | | | | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 | | | | | | | | | | | | | | | 10-20 yrs. | | | | | | | | | | | | | | |
| (b) Coronary Atherosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Arteriosclerosis, Generalized | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Infarction Basal Nuclei Brain - left (old) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | CHIEF MEDICAL EXAMINER | | | | | | | | | | 22b. DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | ASSISTANT MEDICAL EXAMINER | | | | | | | | | | 10-6-68 | | | | | | | | | |
| Edward W. Dittus III, M.D. | | | | | | | | | | DEPUTY MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | | |
| 217 W. Washington St. Hagerstown, Md. | | | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 10/9/1968 | | | | | Queens Point Cemetery | | | | | Keyser, Mineral W. Va. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Charles E. Hafer | | | | | | | | | | OCT 9 1968 | | | | | | | | | | Charles Judge | | | | | | | | | |
| Charles E. Hafer, 230 Balto Ave. Cumberland, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15085 | | | | | | | | | | 15095 | | | | | | | | | | | | | | | | | | | |
|--|--|--|---------|--|--|------------------|--|--|---------------------------------|--|--|-----------------|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| Nancy Christabelle McCleary | | | | | | | | | | Oct. 18, 1968 | | | | | M | | | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Female | | | white | | | Nov. 4, 1885 | | | 82 YRS. | | | MONTHS DAYS | | | HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| West Virginia | | | | | USA | | | | | | | | | | Washington Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Hagerstown | | | | | 330 Liberty Street | | | | | Seamstress | | | | | Dress Maker | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | 13b. CITY OR TOWN | | | | | 13c. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | |
| Maryland | | | | | Washington Hagerstown | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 330 Liberty Street | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| James Hensel Kees | | | | | Sarah Anna Kendrick | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | 330 Liberty Street | | | | | | | | | | | | | | |
| Yes, no, or unknown | | | | | (If yes give war or dates of service) | | | | | 214-09-0421 | | | | | Mr. Allen Kees Hagerstown, Maryland | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Starvation | | | | | | | | | | | | | | | 2-3 hrs | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) No eating | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT-RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Arteriosclerotic Cardiac Dis; Osteoarthritis advanced, Senility | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | City or Town County State | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No. | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1976, 1958, to Date, 1968, that (I) (we) last saw the deceased alive on 15 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| Richard T. Binford MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| Richard T. Binford MD | | | | | | | | | | | | | | | 1135 Potomac Avenue Hagerstown, Md. 21740 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | Oct. 18, 1968 | | | | | Cedar Hill Cemetery | | | | | Greencastle, Franklin, Pa. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Albert L. Leaf | | | | | | | | | | OCT 18 1968 | | | | | | | | | | J Charles Judge | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 15086 | | 15096 | | | |
|---|-------------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Kathryne Leiter McGraw | | 2a. DATE OF DEATH
Month Day Year
October 29, 1968 | | 2b. HOUR
P.M.
4:00 | |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
2-3-1897 | | 6. AGE (In years
lost birthday)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Washington | | 9b. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Avalon Manor | |
| 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Book Keeper | | 12b. KIND OF BUSINESS OR
INDUSTRY
Bottling, Co. | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | |
| 13b. COUNTY
Wash. | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
117 North, Ave. | | 14. FATHER'S NAME First Middle Last
Aaron K. McGraw | | 15. MOTHER'S MAIDEN NAME First Middle Last
Fannie Leiter | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-09-0647 | | 17. INFORMANT Address
Mr. A. Kretzer McGraw Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4339 IMMEDIATE CAUSE (a) Bilateral Lobular Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Rotavirus, genit. & cerebral
DUE TO, OR AS A CONSEQUENCE OF
(c) Diarrhea
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3328 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-5 days
10-15 yrs | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Ac. Depressive Reaction | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 10, 1968 , to OCT 29, 1968 , that (I) (we) last saw the deceased alive on OCT 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward W. Ditto III | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-30-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Edward W. Ditto, III, M.D. | | 22e. ADDRESS
217 W. Washington Street
Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10-31-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Minnich Funeral Home Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
DATE
NOV 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15087 | | | | | | | | | | 15097 | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|---|--|-----------------------------------|--|--|-------------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| First Middle Last
Ethel Leona Miller | | | | | | | | | | 10 Month 1 Day 68 Year 4.05 P M | | | | | | | | | |
| 3. SEX
female | | | 4. RACE
white | | | 5. DATE OF BIRTH
10-21-09 | | | 6. AGE (In years last birthday)
58 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Washington Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. Co. Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Wash. | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
4 W. Magnolia | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
William J. Klipp | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Gertrude L. Angle | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)
none | | | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Walter E. Miller Hagerstown, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage
4300 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive vascular Disease 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
330X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 days | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 19, 1968, to Oct 1, 1968, that (I) (we) last saw the deceased alive on Oct 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
Charles A. Hoffman DEGREE
22d. PHYSICIAN'S NAME (Type)
1104d A. Hoffman | | 22c. DATE SIGNED
10/2/68 | | | | | | | |
| 22e. ADDRESS
214 N. Potomac St. Hagerstown | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | | 23b. DATE
10-4-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Minnich Funeral Home Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 4 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-768

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15088
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15098

| | | | | | | |
|---|--|--|--|---|-----------------------|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Irene Elva Miller | | | 2a. DATE OF DEATH
Month Day Year
October 29, 1968 | | 2b. HOUR
8:15
M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
8-4-1888 | | 6. AGE (in years last birthday)
80 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. County Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Wash. | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last
Charles Miller | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Winfield | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs. Irene Hutzell Hagerstown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
174X IMMEDIATE CAUSE (a) Pulmonary infarct
DUE TO, OR AS A CONSEQUENCE OF
(b) Phlebotrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Mastectomy 1 breast, carcinoma
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
indef
1 mo + | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
170X None | | | | | | |
| 19a. DATE OF OPERATION
10-25-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 9, 1962 , to 10-28, 1968 , that (I) (we) last saw the deceased alive on 10-28 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Robert F. Keagle | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-30-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT F KEAGLE | | 22e. ADDRESS
HAGERSTOWN. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
11-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | |
| 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home Hagerstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE NOV 4 1968 | | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15089

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15099

| | | | | | | | | |
|--|----------------------|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Mary Ellen Montgomery | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 10 7 1968 | | | 2b. HOUR 9:55 A.M. | | |
| 3. SEX female | 4. RACE White | 5. DATE OF BIRTH 8-20-1878 | 6. AGE (in years last birthday) 90 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month 10 Day 7 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Williamsport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY Baltimore | | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 285 Lord Byron Lane | | |
| 14. FATHER'S NAME First George A. Middle Lamley Last Lamley | | | 15. MOTHER'S MAIDEN NAME First Mary K. Middle Bowers Last Bowers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO. 220-46-8000J | | 17. INFORMANT ADDRESS 1 Mrs. Edna E. Hewitt Cockeysville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture Femur and shock
DUE TO, OR AS A CONSEQUENCE OF Secondary to
(b) Advanced arteriosclerotic vascular
DUE TO, OR AS A CONSEQUENCE OF Diseme
(c) Diseme
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 hr.
25 yr. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION 10-6-1968 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year 10-6-1968 HOUR A.M. 6 P.M. 6 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell in Hallway of church Home | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Church Home | | 21f. LOCATION Street or R.F.D. No. Mr. Williamsport City or Town Wash County Md State Md | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto, III, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 10-8-68 | | |
| EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10-10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR OCT 11 1968 | | 25b. REGISTRAR'S SIGNATURE f Charles Judge | | |

• 300 •

100-100000-0

0221 51730

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15090

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15100

| | | | | | | | |
|--|------------------|--|---|---|---|--|--|
| 1. DECEASED-NAME (Type or Print) ELIZABETH HELEN MOWEN | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 10 Day 4 Year 1968 | | | 21. HOUR OF DEATH 7:40 P.M. | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH 3-4-1891 | 6. AGE (In years last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN. 0 | 22. DATE PRONOUNCED DEAD October 4 Year 1968 2d. HOUR 7:40 P.M. | |
| 70. BIRTHPLACE (State or foreign country) IO WA | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND | | 13b. CITY OR TOWN Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME George Bassett | | 15. MOTHER'S MAIDEN NAME Sara Johnson | | 13e. STREET AND NUMBER 1336 Fairchild Ave. | | | |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 213 18 954 | | 17. INFORMANT LEROY B. MOWEN | | ADDRESS Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis
342X
DUE TO, OR AS A CONSEQUENCE OF Parkinsonism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 350X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 3/15 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell from bed | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) State Hospital | | 21f. LOCATION Street or R.F.D. No. 1500 Pennsylvania City or Town Hagerstown County Wash State Maryland | | | |
| 220. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE E. W. Ditto, Jr. | | EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10/4/68 | |
| 230. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10/8/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown-Washington-Md. | |
| 24. FUNERAL DIRECTOR Wm. C. Hunt | | ADDRESS Rest Haven Funeral Chapel Hagerstown, Md. | | 250. REC'D BY REGISTRAR OCT 7 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

1810

1800

WASHINGTON

NOV 10 1899

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON

TO THE SECRETARY OF THE INTERIOR

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

RE: [Illegible]

TO THE SECRETARY OF THE INTERIOR

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

TO THE SECRETARY OF THE INTERIOR

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

Wm. C. Hart

NOV 10 1899

TO THE SECRETARY OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Ora | | Middle
V. | | Last
Nave | | 2a. DATE OF DEATH
Month 14 Day 1968 Year | | 2b. HOUR
10:15 ^A _M | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
6/1/05 | | | 6. AGE (In years last birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Allegany | | | 13c. CITY OR TOWN
Cumberland | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
343 Bedford Street | | |
| 14. FATHER'S NAME
First Robert M. Middle Isler Last | | | 15. MOTHER'S MAIDEN NAME
First Hattie C. Middle (Unknown) Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-32-3299 | | | 17. INFORMANT
Address
Mr. Lester Lee Sr. 343 Bedford St. City | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of cervix with metastasis
180X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yrs. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from May 28 , 19 68 , to Oct. 14 , 19 68 , that (I) (we) last saw the deceased alive on Oct. 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (dictate) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Fe U. Porciuncula M.D. | | | 22c. DATE SIGNED
October 14, 1968 | | | 22d. PHYSICIAN'S NAME (Type)
Fe U. Porciuncula, M.D. | | | 22e. ADDRESS
Western Maryland State Hospital
1500 Pennsylvania Ave., Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Oct. 17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Friendship Cem. | | | 23d. LOCATION (City or Town) (County) (State)
Centerville Panna | | | | | |
| 24. FUNERAL DIRECTOR
Louis Stein Inc. Cumberland Md | | | 25a. REC'D BY REGISTRAR
DATE OCT 17 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

10131

10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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15092

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

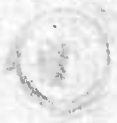
15102

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Earl Elmer Neville | | | 2a. DATE OF DEATH
Month October Day 20 Year 1968 | | | 2b. HOUR
2:35 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
November 30, 1907 | | | 6. AGE (In years last birthday)
60 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Co. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Boiler Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Railroad | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
603 Wise St. | |
| 14. FATHER'S NAME First Middle Last
Charles Patrick Neville | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Agnes Johns | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
705-10-6593 | | 17. INFORMANT Address
Mrs. E.E. Neville 603 Wise St. Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor Pulmonale
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 527L
(b) 2nd degree pulmonary hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) unknown
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
unknown | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Spontaneous Pneumothorax | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State
7-1 624 Oct 20 1968 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-1 , 19 68 to Oct 20 , 19 68 , that (I) (we) lost saw the deceased alive on Oct 20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. R. Ardizzone | | 22c. PHYSICIAN'S NAME (Type)
E. R. Ardizzone | | 22d. ADDRESS
300 W. D. Kane, Hagerstown, Md. | | 22e. DATE SIGNED
10-21-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/23/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR
Wm. C. Hunt | | 24b. ADDRESS
Rest Haven Funeral Chapel | | 24c. CITY
Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 15093 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15104 | | | |
|--|--|--|--|--|--|--|--|------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| First Middle Last
Hallie Berdella Perrott | | | | Month Day Year
October 29 1968 | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | White | | February 15, 1909 | | 59 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Perriessville, O. | | USA | | | | Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Hagerstown | | Washington Co. Hospital | | Housewife | | Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Washington | | Hagerstown | | | | 409 Freemont St. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | | | |
| William Doherty | | Daniel Miller | | Lillie Ann | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| No | | 220-26-7365 | | Mr. Wm. J. Perrott 431 Carrollton Ave. Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | Approximately 3 hr. | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | Indefinite | |
| (b) Arteriosclerotic heart disease with | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Coronary thrombosis | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 420 Diabetes mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 7, 1962, to Oct. 29, 1968, that (I) (we) last saw the deceased alive on Oct. 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | M.D. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| B. B. Kneisley, M.D. | | | | | | 10/29/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| B. B. Kneisley, M.D. | | 148 West Washington Street Hagerstown, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 10/31/68 | | Rest Haven Cemetery | | Hagerstown-Washington Md. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Rest Haven Funeral Chapel | | Hagerstown, Md. | | DATE OCT 31 1968 | | J. Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15094

15105

| | | | | | | | | |
|---|---------|--|------------------|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Carson Rae Potter | | | | | October 14, 1968 | | 3:00A M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | White | | June 7, 1899 | | 69 YRS. | | 4 7 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Tarronsburg, Md. | | U. S. A. | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | Washington Co. Hospital | | Salesman | | Granite Works | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Washington | | Knoxville | | | | Rfd. 2 |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| Joseph E. Potter | | | | | Pinkie Long | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No. | | 219-05-2535 | | Mrs. Maude Potter, Rfd. 2, Knoxville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>4339</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 Day</u>
<u>year</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>332 x Fracture vertebrae</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> , 19 <u>66</u> , to <u>10-14-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-14-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>J. J. Secondari</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>10-14-68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>J. J. SECONDARI</u> | | 22e. ADDRESS <u>Boonsboro, Md.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 10-16-68 | | Brownsville Hgts. Cemetery | | Brownsville, Wash. Co., Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | OCT 18 1968 | | <u>Charles Judge</u> | | |

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Dr. John H. Bates, 41-112 N. Main St., Boonshoro, Wis.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Edna Catherine Pownall | | | | | | 10 Month 2 Day 1968 | | 6:15 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | 4/23/84 | | 84 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| New York | | USA | | | | WASHINGTON | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | |
| HAGERSTOWN | | | WESTERN MD. STATE HOSPITAL | | | Eastman Kodak Co Retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8030 Park Overlook Dr. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| William Henry Pownall | | | Caroline Hill | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 073-03-3829 | | Mrs Judith von Oppenfeld 20034
8030 Overlook Dr Bethesda Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary embolism | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Generalized arteriosclerosis with CVA | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 331X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 18, 1968, to Oct. 2, 1968, that (I) (we) last saw the deceased alive on October 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | |
| Domingo A. Garcia | | | | | | 10/3/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| Domingo A. Garcia, M.D. | | | | | | Western Md. State Hospital
1500 Pennsylvania Ave., Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Removal | | 10/3/68 | | Pike Cemetery | | Pike Wyoming Co New York | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Andrew K. Coffman Hagerstown Md. | | | | | | OCT 7 1968 | | Charles Judge | | |

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WASHINGTON

Division of Research and Statistics

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Removal of the Cemetery

Andrew K. Coleman Funeral Home Inc

1953

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15096

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15107

| | | | | | | | | | | | | | |
|---|---------|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month Day Year | | 5:20
1968 | |
| ALMIRA | | MAY | | RUBY | | | | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | | OCTOBER 20 | | 1968 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years
lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 5:20
1968 | |
| FEMALE | WHITE | 11/2/1876 | | 91 YRS. | | MONTHS DAYS | | HOURS MIN | | Month Day Year | | October 20, 1968 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md. | |
| Virginia | | U.S.A. | | | | WASHINGTON | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| HAGERSTOWN | | WASHINGTON CO. HOSPITAL | | HOUSEWIFE | | HOME | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| MARYLAND | | WASHINGTON | | HAGERSTOWN | | | | 204 N. LOCUST ST. | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle Last | |
| EUGENE | | STONEBURNER | | ELIZABETH | | ANN CRAWFORD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 770-522107 | | MRS. MILDRED WOLF | | HAGERSTOWN MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonitis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>General Arteriosclerosis, Severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Fractured Femur</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Several day's
Several years
60 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR <u>5</u> P.M. <u>10-17-</u> 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Slipped while standing beside bed in</u> | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
<u>Martin Manor Nursing Home, Virginia Ave., Hagerstown, Washington, Md.</u> | | 21f. CITY OR TOWN
<u>Hagerstown</u> County <u>Washington</u> State <u>Md.</u> | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | Dr. E. W. Ditto, Jr. | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>10-21-68</u> | |
| EXAMINER'S
NAME (Type) | | Dr. E. W. Ditto, Jr. | | 215 W. Washington St., Hagerstown, Md. | | ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| BURIAL | | 10/23/68 | | REST HAVEN CEM. | | HAGERSTOWN WASH. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| W. J. Norman | | Hagerstown, Md. | | OCT 25 1968 | | Charles Judge | | | | | | | |

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ALBERT RUBY

EMILIE ALICE

Virginia

U.S.A.

WASHINGTON CO. MARYLAND

WASHINGTON CO. MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A157-1
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15097

CERTIFICATE OF DEATH

15108

| | | | | | | | |
|---|--|---|-------------------------|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | First
Diane | Middle
Karren | Last
Sadler | 2a. DATE OF DEATH
Oct. 20 19 68 | | 2b. HOUR
M |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
April 30 1946 | | 6. AGE (In years
lost birthday)
22 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
Hagerstown Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Washington County | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
House Wife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Charles E Messner Jr. | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Wahnetta Williams | | 13e. STREET AND NUMBER
431 Antietam Drive | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) no | | 16b. SOCIAL SECURITY NO.
219-44-4371 | | 17. INFORMANT
Paul K Sadler Jr. Address
431 Antietam Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1729 IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant melanoma
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
3 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
1909 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-23 , 19 63 , to 10-20 , 19 68 , that (I) (we) last saw the deceased alive on 10-19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Charles F. Hess | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-21-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Charles F. Hess, M.D. | | | | 22e. ADDRESS
Smithsburg, Maryland 21783 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
Oct. 22 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Wolfsville Lutheran Cem. | | 23d. LOCATION (City or Town) (County) (State)
Wolfsville Fred. Md. | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home | | | | ADDRESS
Smithsburg Md. | | 25a. REC'D BY REGISTRAR
OCT 23 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15098

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15109

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
REBECCA FRANCES SHANHOLTZ | | | 2a. DATE OF DEATH Month Day Year
October 16 1968 | | | 2b. HOUR PM
12.15 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Sept 6 1886 | | 6. AGE (In years lost birthday)
82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
824 Jefferson St | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1057 Georgia Ave | | 14. FATHER'S NAME First Middle Last
(no record) Marshall | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary B. Henson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) --- | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Melvin C. Shanholtz 1057 Georgia Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
4100 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive CV Dis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 hours
8 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-15 , 19 67 , to 10-16 , 19 68 , that (I) (we) last saw the deceased alive on 10-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert P. Conrad DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
10-17-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert P. Conrad | | | | | | 22e. ADDRESS
137 W. Washington Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Wash Co Md. | |
| 24. FUNERAL DIRECTOR
Andrew K. Coffman Funeral Home Inc | | | | 25a. REC'D BY REGISTRAR
OCT 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

12168

CERTIFICATE OF MARRIAGE

15083

October 10 1968 12:15

REBECCA FRANCES SHANNON

female white Sept 6 1886 22

Maryland U.S.A. X Washington

Hagerstown 524 Jefferson St Houswife Own home

Maryland Washington Hagerstown X 1087 Georgia Ave

(no record) Marshall Mary M. Henson

No --- Home Melvin C. Shannon 1087 Georgia Ave

Washington D

10/19/68 Rose Hill Cemetery Hagerstown Wash D.C.

Oct 18 1968

Andrew X. Collins Hagerstown Home Inc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15110

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Flemmie Catherine Shifflet | | | 2a. DATE OF DEATH
Month October Day 17 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
November 19, 1896 | | 6. AGE (In years lost birthday)
71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Rockingham Co., Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Hyalon Manor Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
641 W. Washington St. | | 14. FATHER'S NAME First Samuel Middle Edward Last Jate | | 15. MOTHER'S MAIDEN NAME First Effie Middle Whisler Last Whisler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown No (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Catherine Blickenstaff | | Address Hagerstown, Md. 312 Nottingham Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral Thrombosis
2509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X
(b) Arteriosclerosis - Gen.
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
13 mo.
4 1/2
10 yrs. + | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Fracture left hip 7/17/68 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 20, 1968 , to Oct. 17, 1968 , that (I) (we) lost saw the deceased alive on Oct 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Doyd A. Hoffmeyer | | DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10/18/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Doyd A. Hoffmeyer | | 22e. ADDRESS
214 N. Potomac St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown-Washington-Md. | |
| 24. FUNERAL DIRECTOR
Wm. C. Horst | | ADDRESS
Rest Haven Funeral Chapel Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1899

12110

THE PRINCE OF WALES

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General

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Wm. C. Horst

1898

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15100

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15111

| | | | | | | | | |
|--|----------------------|---|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print)
Donald Eugene Shindledecker | | | 2a. DATE KNOWN OF DEATH
Month 10 Day 28 Year 1968 | | | 2b. HOUR
1:00 P.M. | | |
| 3. SEX
Male | 4. RACE
W. | 5. DATE OF BIRTH
3/23/39 | 6. AGE (in years last birthday)
29 YRS. | IF UNDER 1 YEAR
MONTHS
29 | IF UNDER 24 HRS.
HOURS
29 | 2c. DATE PRONOUNCED DEAD
Month 10 Day 28 Year 1968 | | 2d. HOUR
3:15 P.M. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | |
| 10. CITY OR TOWN OF DEATH
Cascade | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Box 48-Cascade | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Labor | | 12b. KIND OF BUSINESS OR INDUSTRY
Book Binding | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Cascade | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
Box 48 | | | 14. FATHER'S NAME
First John Middle G. Last Shindledecker | | | 15. MOTHER'S MAIDEN NAME
First Josephine Middle Recker Last Box 48 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO.
215-36-5816 | | 17. INFORMANT
Mrs. Donald E. Shindledecker | | | |
| 16c. ADDRESS
Cascade, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: Self-inflicted gunshot wound through the heart.
IMMEDIATE CAUSE (a) 955X
DUE TO, OR AS A CONSEQUENCE OF (b) Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 976X
DUE TO, OR AS A CONSEQUENCE OF (c) 976X | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION
976X | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 10:28 P.M. 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Self-inflicted. | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Basement-Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Cascade Wash. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Howard N. Weeks | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
10/28/68 | | |
| EXAMINER'S NAME (Type)
Howard N. Weeks, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | ADDRESS (Street, city, town, or county)
Washington | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/31/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Bethel | | 23d. LOCATION (City or Town) (County) (State)
Lantz R.D.1, Frederick, Md. | | |
| 24. FUNERAL DIRECTOR
Walter G. Goe | | | | ADDRESS
Waynesboro, Penna. | | 25a. REC'D BY REGISTRAR
OCT 30 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge |

1211

10/31/1908

Maryland

U.S.A.

Book Binding

Label

X Box 18

Washington Cascade

Maryland

John O. Zindler

Josephine

Becker

Box 18

212-36-2115 Mrs. Donald E. Zindler, Cascade, Md.

no

Labels E. J. I. Frederick, Md.

Labels 10/31/1908

Waynesboro, Penna.

OCT 30 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 15101 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15112 | |
|--|--|--|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | 2b. HOUR |
| First Middle Last
Lillian Ann Shoemaker | | | | | Month Day Year
October 25, 1968 | | 7:00P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | |
| Female | | White | | June 27, 1899 | | 69 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
(give street address) | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Luray, Va. | | U. S. A. | | Washington | | Washington Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Hagerstown | | Washington Co. Hospital | | Housewife | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | Washington | | Hagerstown | | 2309 Virginia Ave. | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | |
| Wilbur Skelton | | | | Mary Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No. | | 219-14-9880 | | Mr. George L. Shoemaker, Rfd. 2 Clearspring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Brain Syndrome with advanced Parkinsonism 3 years
342X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 350X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Moderate Hypertensive Vasc. Disease. Chronic Cholecystitis. Umbilical Hernia. Arthritis degenerative. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) this hospital attended the deceased from Oct 11 , 1968, to Oct 25 , 1968, that (I) (we) last saw the deceased alive on Oct 24 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. Pronounced dead by J.J. Dobbie, M.D. | | | | | | | |
| 22b. SIGNATURE W. J. Layman, M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
October 29 1968 | |
| 22d. PHYSICIAN'S NAME (Type) William Templeton Layman, M.D | | | | 22e. ADDRESS
301 E. Antietam St., Hagerstown, Md. 21740 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 10- 28-68 | | Mountain View Cemetery | | Sharpsburg, Wash. Co., Md. | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | NOV 1 1968 | | J. Charles Judge | |

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18112

William Ann Shoemaker October 25, 1958 7:00 PM

Female White June 27, 1958 82

University of Maryland U.S.A. Washington

Department of Biology Washington D.C. 20541

University of Maryland Washington D.C. 20541

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

October 29, 1958

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

John H. Bates 112 E. Main St. Annapolis, Md. 21401

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|--|---|--|---|---|--|--|---|---|------------------------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| 15102 | | | | | 15113 | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | | | |
| Joseph M. Shupp | | | | | | | | | Oct. 14 1968 | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| Male | | | White | | Dec. 10, 1878 | | | 89 | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | 10. HOUR | | |
| Charlton, Md. | | | U.S.A. | | | | | Washington | | | 10 A. M. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Rd. 1 Clear Spring | | | Route 1 | | | Farmer | | | Retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | | Clear Spring | | | # | | Route 1 | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| Daniel | | | # | | Shupp | | | | Savilla | | | # Weller | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| No | | | None | | | 214-54-0633 | | | Edward Shupp | | | Rd. 1, Clear Spring, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Vascular Disease, Severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Senility</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4500 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 15, 1968, to Oct. 14, 1968, that (I) (we) last
saw the deceased alive on Oct. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
A. E. W. Ditto, Jr. | | | | | | | | DEGREE | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
Oct. 15, 1968 | |
| 22d. PHYSICIAN'S
NAME (Type) Dr. E. W. Ditto, Jr. | | | | | | | | 22e. ADDRESS
215 W. Washington St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) (State) | | | |
| Burial | | | 10/17/68 | | St. Pauls Cemetery | | | Washington Co. | | Md. | | | |
| 24. FUNERAL DIRECTOR
Margaret Rowland | | | | | | ADDRESS
Clear Spring, Md. | | 25a. REC'D BY REGISTRAR
OCT 18 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

12113

12102

IN 1908

Dec. 10, 1908

Washington, D.C.

Mr. J. Edgar Hoover

Department of Justice

Washington, D.C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours,
J. Edgar Hoover

Special Agent in Charge

Department of Justice

Washington, D.C.

Very truly yours,

J. Edgar Hoover

Special Agent in Charge

Department of Justice

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 451 (4)
30M REV. 1/68

| | | | | | | | |
|--|--|--|-----------------|---|--|---|------------------|
| 15103 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH | | | | 15114 | |
| 1. DECEASED-NAME
(Type or print) | | First
ETHEL | Middle
PEARL | Last
SKELTON | 2a. DATE OF DEATH
Month 10 Day 1968 | | 2b. HOUR
15 A |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
12/9/1899 | | 6. AGE (In years
last birthday)
68 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give the address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of last year or retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR
INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First
ISAAC
Middle
NEWTON
Last
HULL | | 15. MOTHER'S MAIDEN NAME
First
ANNIE
Middle
ISABELLE
Last
HARPER | | 13e. STREET AND NUMBER
826 POPE AVE. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
214-09-5604 | | 17. INFORMANT
Address
MRS. GRACE C. FULL HAGERSTOWN MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Probable acute coronary occlusion</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <u>4201</u>
(b) <u>Atherosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 min.

unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Hypertensive cardiovascular disease with cerebral hemorrhage (June 29)</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the deceased) attended the deceased from <u>June 21</u> , 19 <u>68</u> , to <u>Oct. 10</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>Oct. 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (didn't) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>W. T. Layman, M.D.</u> | | | | DEGREE
ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
October 11, 1968 | |
| 22d. PHYSICIAN'S
NAME (Type) William T. Layman, M.D. | | 22e. ADDRESS
301 E. Antietam Street, Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REUR | | 23b. DATE
10/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | |
| 24. FUNERAL DIRECTOR
<u>W. J. Norment, Hagerstown, Md.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE OCT 16 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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1/24/42

WASH. D.C.

WASH. D.C.

WASH. D.C. 1/24/42

WASH. D.C. 1/24/42

WASH. D.C. 1/24/42

WASH. D.C. 1/24/42

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WASH. D.C. 1/24/42

WASH. D.C. 1/24/42

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| MARIAN | | | ELINOR | | | SLOCUM | | | OCTOBER Month 20 Day 68 Year 6:10AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| FEMALE | | WHITE | | SEPTEMBER 29, 1898 | | | 70 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MICHIGAN | | U.S.A. | | | | WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HAGERSTOWN | | | WASHINGTON COUNTY HOSP. | | | MUSIC TEACHER | | | TEACHING |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | WASHINGTON | | HAGERSTOWN | | | 945 GREENERIER ROAD | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| EARL CLARK SLOCUM | | | LU ARMSTRONG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | | 215-36-6914 | | 945 Address GREENBRIAR RD. HAGERSTOWN, MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma of the gallbladder</u> | | | | | | | | | 9 months |
| 1560 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 1551 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>68</u> , to <u>OCT 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>OCT 19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| <u>Richard E. Smith, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 10/21/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| DALTON M WELTY, M.D. | | | | 998 POTOMAC AVE., HAGERSTOWN, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| BURIAL | | 10/24/68 | | WEST SIDE CEMETERY | | GRASS LAKE | | | MICHIGAN |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Charles M. Rouger</u> | | | | HAGERSTOWN, MARYLAND | | DATE OCT 22 1968 | | <u>g Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|--|---------------------------------|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 15105 | | | | | 15116 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| VIRGINIA HARRIGAN STAINS | | | | | October 28 1968 | | | 1 A | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Jany 30 1902 | | | 66 YRS. | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | Wash County Hospital | | | Housewife | | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Washington | | Hagerstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17 West Baltimore St | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| John Harrigan | | | | No Record | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No ---- | | | | 215-18-2040 | | George P. Stains Jr. 17 W. Baltimore Hagerstown Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes Mellitus</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>260x</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 22, 1968</u> to <u>18 Oct, 1968</u> , that (I) (we) lost saw the deceased alive on <u>18 Oct</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Andrew K. Coffman</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>10/29/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 10/30/68 | | Rose Hill Cemetery | | Hagerstown Wash Co Md | | | | |
| 24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u> | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| | | | | DATE <u>OCT 31 1968</u> | | <u>Charles Judge</u> | | | | |

12102

12112

VIRGINIA HARRISON STATE October 25 1958 1 A

Female White January 30 1902 66

Maryland U. A. Washington

Hagerstown Wash County Hospital Cousawia 2000 Home

Maryland Washington Hagerstown 17 1958 Baltimore 38

John Harrison in record

215-18-204 George W. State 17 W. Baltimore

October 10 30/58 Hagerstown Wash Co Md

Funeral Home Inc 021 81 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
HERMAN | | | Middle
CECIL | | | Last
STOUFFER | | |
| 2a. DATE OF DEATH | | | Month
Oct. | | | Day
26 | | | Year
1968 | | |
| 3. SEX
Male | | | 4. RACE
White | | | 5. DATE OF BIRTH
Oct. 10 1904 | | | 2b. HOUR
M | | |
| 7a. BIRTHPLACE (State or foreign country)
Mt. Lena Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 6. AGE (In years last birthday)
64 YRS. | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington County | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Orchardist | | | 12b. KIND OF BUSINESS OR INDUSTRY
Fruit Grower | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Wash. | | | 13c. CITY OR TOWN
Chewsville | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
First
ELMER | | | Middle
STOUFFER | | | 15. MOTHER'S MAIDEN NAME
First
GELINA | | | Last
IRVING | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)
no | | | 16b. SOCIAL SECURITY NO.
578-24-3974 | | | 17. INFORMANT
Mrs. Anna Ruth Stouffer | | | Address
Chewsville Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Dissecting Aortic Aneurysm</i>
441.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
9 hrs
years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
451X none | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 25 Oct 1968, to 26 Oct 1968, that (I) (we) last saw the deceased alive on 26 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>J. Smith</i> | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
10/27/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Oct. 29 68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Cavetown reformed Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Cavetown Wash. County | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home | | | ADDRESS
Smithsburg Md. | | | 25a. REC'D BY REGISTRAR
DATE
OCT 31 1968 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

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Abstract

1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

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CERTIFICATE OF DEATH

15117

15107

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) ADRIAN HANNIBAL Alexander SUMMONS | | | 2a. DATE OF DEATH OCT. 9 1968 | | | 2b. HOUR 7P.M. | | | | | |
| 3. SEX MALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH 11/14/1907 | | 6. AGE (In years lost birthday) 60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER-ACME ADAPTOIR'S | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PENNA. | | | 13b. CITY OR TOWN GREENCASTLE | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET AND NUMBER 114 S. JEFFERSON ST. | | | | |
| 14. FATHER'S NAME First SANDY Middle SUMMONS Last SUMMONS | | | | 15. MOTHER'S MAIDEN NAME First JEMMIAMA Middle SUMMONS Last SUMMONS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 204-01-4848 | | 17. INFORMANT Ella T. Dixon - 114 S. Jefferson St. Greencastle, PA. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1541
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenocarcinoma of rectum
DUE TO, OR AS A CONSEQUENCE OF
(c) 1 year | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
154X | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/29/68 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of rectum | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 68 , to 10/9 , 19 68 , that (I) (we) last saw the deceased alive on 10/9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. C. Brewer | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 10/10/68 | | |
| 22d. PHYSICIAN'S NAME (Type) W. C. Brewer | | | | | | 22e. ADDRESS GREENCASTLE, PENNA. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 10/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Greencastle, PA. | | | |
| 24. FUNERAL DIRECTOR A.C. Munnich - Greencastle, PA. | | | | | | 25a. REC'D BY REGISTRAR OC 14 1968 | | | 25b. REGISTRAR'S SIGNATURE James J. J... | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 15108 | | | | | | | | | | 15118 | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|---|--|---|--|--|--|--|---|---|----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last
Dorothy Belle Swisher | | | | | | | | | | 2a. DATE KNOWN OF DEATH Month Day Year
10-4-1968 | | | | | 2b. HOUR
3:30 PM | | | | | | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 2, 1915 | | 6. AGE (In years last birthday)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | IF UNDER 24 HRS.
HOURS MIN.
0 0 | | 2c. DATE PRONOUNCED DEAD Month Day Year
Oct. 4 1968 | | | | | 2d. HOUR
3:30 PM | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Washington Md. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Beaver Creek Road | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. COUNTY
Washington | | | | 13c. CITY OR TOWN
Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
R # 3, Hagerstown, Md. | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Frederick Henson | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Charlotte Patterson | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | | | | | | | | 16b. SOCIAL SECURITY NO.
None | | | | | | | | | |
| 17. INFORMANT
Charles Robert Swisher, R # 3 | | | | | | | | | | ADDRESS
Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Adrenal Tumor | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
instant | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4301 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE A. SWISHER M.D. | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED 10-6-68 | | | | | | | | | |
| EXAMINER'S NAME (Type) Dr. F. W. H. T. T. T. | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
10/7/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Wash. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Coffman Funeral Home, Inc., Hagerstown Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR
OCT 10 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

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Swisher

Belie

Dorothy

Female White July 2, 1915 33

x

Washington

U.S.A.

Maryland

Beaver Creek Road

Honolulu

Hagerston

Washington Hagerstown

x R. W. 3, Hagerstown, Md.

Maryland

Henson

Charlotte

Frederick

Hagerston

Charles Robert Swisher, R. W. 3

no

Burial 10/7/53 Rose Hill Cemetery Hagerston, Md.

Coffman Funeral Home, Inc., Hagerston

OCT 10 1953

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 Maryland State Department of Health
11-13-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 11 File No. 10-11-68-15119

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15119

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(Type or Print)
15109 Diane | | First
Martha | | Middle
Twigg | | Last | | 2a. DATE KNOWN OF DEATH
Month 10 Day 10 Year 1968 | | 2b. HOUR
7:30 M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
2-22-1949 | | 6. AGE (in years last birthday)
19 YRS | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Fort Ritchie | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mountain Area-Near Ft. Ritchie, Md. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Dealer | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Bedford Road | | | |
| 14. FATHER'S NAME
First C. Edward Middle Twigg Last | | | | 15. MOTHER'S MAIDEN NAME
First Betty Middle Hansrote Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT ADDRESS
Mr. C. Edward Twigg Cumberland, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
841.4 IMMEDIATE CAUSE (a) 1 PULMONARY - Multiple traumatic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF injuries and fracture
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
863x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 7:30 P.M. 10-10 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Air-plane crash | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Mountain Area | | 21f. LOCATION Street or R.F.D. No.
Nr. Fort Ritchie | | City or Town
Wash. | | County
Md. | | State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Schwald W. Ditto | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
10-11-68 | | | |
| EXAMINER'S NAME (Type)
Edward W. Ditto, 111, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | JUNIOR MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town)
Cumberland, Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
Silcox Funeral Service Cumberland, Md. | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR
1968 | | 25b. REC'D BY REGISTRAR
1968 | |
| DATE
OCT 14 1968 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) THEODORE HENRY WEAVER | | | 2a. DATE OF DEATH
Month 9 Day 68 Year 1968 | | | 2b. HOUR 12:50 M | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
JANUARY 13, 1888 | | 6. AGE (In years lost birthday)
80 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON COUNTY HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
RETIRED CABINETMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY
ORGAN FACTORY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN FUNKSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
106 S. ANTIETAM ST. | |
| 14. FATHER'S NAME First WILLIAM Middle H Last WEAVER | | | 15. MOTHER'S MAIDEN NAME First ELLEN Middle MC COY Last MC COY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-09-8007A | | 17. INFORMANT
MRS. NORA WEAVER, | | 106 Address S. ANTIETAM ST. FUNKSTOWN, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary emphysema, advanced, bilateral, with right ventricular failure
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 5271
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 1/2 hr. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Prostatic hypertrophy with obstruction | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year 19
P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | |
| 22a. I certify that (I) (did not) attended the deceased from Oct. 8 , 19 68 , to Oct. 9 , 19 68 , that (I) (did) last saw the deceased alive on Oct. 8 , 19 68 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
B.B. Kniesley | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10/9/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
B.B. KNIESLEY, M. D. | | | | | 22e. ADDRESS
148 W WASHINGTON ST., HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
10/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY
FUNKSTOWN CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
FUNKSTOWN, WASHINGTON, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
Charles M. Rouzer | | | | | ADDRESS
HAGERSTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR
DATE OCT 14 1968 | | 25b. REGISTERED SIGNATURE
[Signature] | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13-68. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 406 Maryland STATE DEPARTMENT OF HEALTH
11-13-68 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15111

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15121

| | | | | | | | | | | | |
|--|---------|------------------|--|--------------------------------|--------------------------------|---|--|--|---|--|--|
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH MATED | | | 2b. HOUR | | |
| Gerald Emerson Weikel | | | | | | 10 10 1968 | | | 7:30 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Male | White | Feb. 4, 1917 | 51 YRS. | | | Month 10 Day 11 Year 1968 | | | 11:58 PM | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Michigan | | | U.S.A. | | | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington County Hospital | | | Parts Mgr. | | | Automobile | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Montgomery | | | Rockville | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | |
| Joseph Weikel | | | Vera | | | Yes | | | 575-05-6725 | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Mary Ella Weikel- wife- same item #13 | | | | | | 841.4 Multiple | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | traumatic injuries and fracture | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 863X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 7:15 P.M. 10-10 19 68 | | | Airplane Crash | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | Mountain Area | | | Nr. Fort Ritchie Wash. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | 217 W. Washington St., Hagerstown, Md. | | | ASSISTANT MEDICAL EXAMINER | | | | | |
| Edward W. Ditto, 111, M.D. | | | | | | DEPUTY MEDICAL EXAMINER | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 10/15/68 | | | Spohrs Cross Roads | | | Berkley Spring, West Va. | | |
| 24. FUNERAL DIRECTOR | | | 1331 Rockville Pike | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Tyson Wheeler Funeral Home Rockville, Md. | | | | | | DATE OCT 15 1968 | | | Charles Judge | | |

12121

12112

Section

12

001 1 2 369

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15112. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1 taken from prev. birth cert. 11/11/66

15122

| | | | | | | | | | | | |
|--|--|-------------------------|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(Last, first, middle)
15112 DEBORAH KAY WILLIAMS | | | 2a. DATE KNOWN OF DEATH
Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/>
Oct. 9, 1968 | | | 2b. HOUR
M <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
June 4, 1968 | | 6. AGE (In years last birthday)
YRS. 4 MONTHS 5 DAYS | | 7c. DATE PRONOUNCED DEAD
Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>
Oct. 9, 1968 | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Washington. | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | | 12b. KIND OF BUSINESS OR INDUSTRY
Infant | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Washington | | | 13c. CITY OR TOWN
Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Downsville, Md. | | |
| 14. FATHER'S NAME First Middle Last
Terry Lee Williams | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Bonnie M. Alexander | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | 16b. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
Terry L. Williams | | | ADDRESS
Fairplay R. #1 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ac. Interstitial pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Achena hypoplasia
DUE TO, OR AS A CONSEQUENCE OF
(c) (S.D.I.)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
484X | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
unknown | | |
| | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
492X | | |
| | | | | | | | | | | | |
| 19a. DATE OF OPERATION
492X | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Edward W. Ditto, III, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| EXAMINER'S NAME (Type) | | | ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED
10-10-68 | | | 22c. LOCATION (City or Town) (County) (State)
Hagerstown, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Oct. 11/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Maryland | | |
| 24. FUNERAL DIRECTOR
Andrew K. Coffman | | | ADDRESS
Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR
OCT 14 1968 | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

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Signature of Applicant

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Terry L. Williams, Esquire

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Andrew K. Cullen, Inc.

628 J. L. T. Jansen et al.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G405 12-11-68
CERTIFICATE OF DEATH

15123

| | | | | | |
|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
ROMAN EDWARD WILLIAMS | | | 2a. DATE OF DEATH
Month Day Year
OCT 7 1968 | | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Sept. 14 1908 | | 6. AGE (In years
lost birthday)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
0 22 |
| 7a. BIRTHPLACE (State or foreign
country)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Washington Md. | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Washington County Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Farmer | 12b. KIND OF BUSINESS OR
INDUSTRY
Farm |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Williamsport | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 13e. STREET AND NUMBER
Williamsport Md. RFD #1 |
| 14. FATHER'S NAME First Middle Last
J. J Williams | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Criner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
216-14-5154 | | 17. INFORMANT Address
Mrs. Catherine S. Williams Williamsport Md. RFD #1 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
486X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
7 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
493X Congestive Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 64 , to Oct , 19 68 , that (I) we last
saw the deceased alive on Oct 7 , 19 68 , and that in (my) our opinion death occurred on the date and hour and from the
causes stated above, (I) we did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
M.E. Byrkit | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
10-10-68 | |
| 22d. PHYSICIAN'S
NAME (Type)
M.E. Byrkit | | 22e. ADDRESS
Williamsport Md | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | 23b. DATE
Oct. 10-68 | 23c. NAME OF CEMETERY OR CREMATORY
Mennonite Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Near Pinesburg Wash. Md. | |
| 24. FUNERAL DIRECTOR
Albert L. Leaf Williamsport, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE
OCT 11 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1913

1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 15114 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 15124 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Russell Edward Wishard | | | 2a. DATE OF DEATH
Month Day Year
Oct. 28 1968 | | | 2b. HOUR
A M
1:20 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
8/17/93 | | 6. AGE (In years lost birthday)
75 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
farming | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
John I. Wishard | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Alice Trumpower | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No -- | | 16b. SOCIAL SECURITY NO.
219-20-1932 | | 17. INFORMANT Address
Mrs Edna E. Wishard | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobular pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the rectum with generalized metastasis, and pyelonephritis
DUE TO, OR AS A CONSEQUENCE OF
(c) Pyelonephritis
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Pyelonephritis | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
1 year | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) the deceased attended the deceased from Oct. 2, 1968 , to Oct. 28, 1968 , that (I) was last saw the deceased alive on Oct. 27, 1968 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (diagnose) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Domingo A. Garcia | | | | | | 22c. DATE SIGNED
Oct. 28, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Domingo A. Garcia, M.D. | | | | | | 22e. ADDRESS
Western Maryland State Hospital
1500 Pennsylvania Ave., Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
10/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dunkard Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Broadfording Wash Co Md. | |
| 24. FUNERAL DIRECTOR
Andrew K. Coffman | | | | 25a. REC'D BY REGISTRAR
DATE
OCT 31 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

15134

15134

Household Telephone Address City State Zip

Mr. & Mrs. J. L. Thompson 1234 Main St. Springfield Ill. 62761

Mr. & Mrs. J. L. Thompson 1234 Main St. Springfield Ill. 62761

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|---|------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Rudolph jesse Witmer | | | | | | Oct. 21 1968 | | 7:30AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | | White | | 8/20/87 | | 81 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Winchester Va. | | | U.S.A. | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Wash. Co. Hospital | | | Retired Wood worker, Floor Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Clear Spring | | Route 1 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| John # Witmer | | | Mary # Curly | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No None | | | 212-24-5086 | | David Witmer, Route 1, Clear Spring Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic Uremia | | | | | | | | | |
| 518X CHRONIC UREMIA | | | | | | | | | |
| (b) Cor Pulmonale | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Bronchiectasis, chronic. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 526X Pulmonary Emphysema and Fibrosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| none | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/09/68, 19, to 10/21/68, 19, that (I) (we) saw the deceased alive on 10/21/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| Archie Robert Cohen, M.D. | | | | | | 10/21/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| Clear Spring, Maryland 21722 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 10/23/68 | | St. Pauls Cemetery | | Western Pike Wash. | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Margaret Rowland, Clear Spring, Md. | | | | DATE OCT 24 1968 | | Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15103

| | | | | | | | | | | | |
|--|--|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Wolfe, Minnie Pearl</u> | | | 2a. DATE OF DEATH
Month <u>Oct</u> Day <u>24</u> Year <u>68</u> | | | 2b. HOUR
<u>4A</u> M | | | | | |
| 3. SEX
<u>F</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
<u>NOV. 20. 1894</u> | | 6. AGE (In years last birthday)
<u>73</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>WASHINGTON</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>HAGERSTOWN</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>WASHINGTON HOSPITAL</u> | | | 12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if retired.)
<u>HOUSEWIFE</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>MD.</u> | | | 13b. COUNTY
<u>WASHINGTON</u> | | 13c. CITY OR TOWN
<u>WMSPT.</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>3 W. POTOMAC ST.</u> | | |
| 14. FATHER'S NAME First Middle Last
<u>CLETUS ZIMMERMAN</u> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>MARY JANE TRUMPOWER</u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | | | |
| 16b. SOCIAL SECURITY NO.
<u>220.26.5857</u> | | | 17. INFORMANT Address
<u>B GORGE W WOLFE 3 W. POTOMAC ST. WMSPT. MD.</u> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>
<u>5749</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Phlebotrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cholecystectomy</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 hr</u>
<u>unknown</u>
<u>31 hr</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>584 Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>22 Oct 68</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>cholelithiasis</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>21 Oct, 1968</u> , to <u>24 Oct, 1968</u> , that (I) (we) last saw the deceased alive on <u>23 Oct, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Frank S. Bumbach MD</u> | | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>24 Oct 68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Frank S. Bumbach</u> | | | | | | 22e. ADDRESS
<u>119 King St Hagerstown</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | 23b. DATE
<u>10.26.68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GREEN LAWN</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>WILLIAMSPORT, WASHINGTON MD</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Howard J. Moore Williamsport Md</u> | | | | | | ADDRESS
<u>Williamsport Md</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 28 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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JOE K. JOE VON

A-2-24

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